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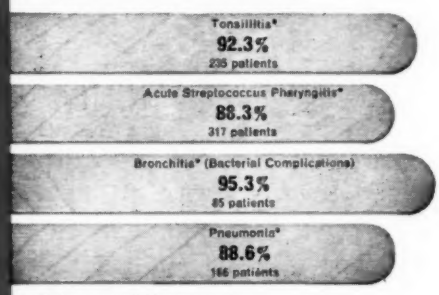

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OCTOBER, 1961 — VOL. 57 NO. 10

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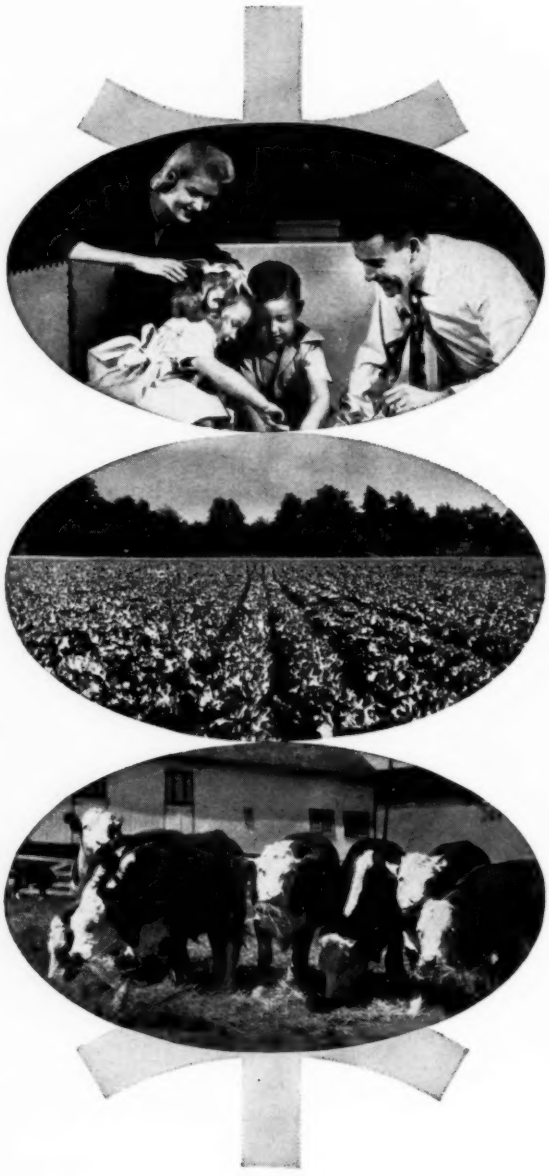

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PROGRESS IN RESEARCH FOR MEDICINE

The Journal
of the
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VOLUME 57 October, 1961 NUMBER 10

BLEEDING IN THE LAST TRIMESTER

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Bleeding in the late months of pregnancy is always pathologic and except in one unique instance, demands investigative procedures. Since vaginal bleeding can be caused by such simple lesions as cervical erosions and granulation on the eroded tissue, to a complete placenta previa it is obvious that it is unwise to study this phenomenon with symptoms or specific entities in mind. It is axiomatic that a pelvic examination in a case of chronic cervicitis has much less significance than one for placenta previa, and yet most of us know the insignificant symptoms which may serve as a prelude to the hemorrhage of the latter. How then does one approach this problem of the last trimester bleeder?

Much information and subsequent diagnosis is available on the first significant communication of physician and patient. It is certain that a patient at term with sudden heavy bleeding needs immediate hospitalization, cross-matched available blood and observation to report vital signs, to estimate blood loss, and finally, to evaluate the fetal status. The real difficulty is the minimal bleeder or spotter not yet at term with this persistent sign of staining for a day or two. At this point a plan of action is in order and a general philosophy of management is indicated.

Since the etiology of the two major potentially catastrophic entities of placenta previa and abruptio placentae are unknown there is nothing to be gained by attempting to diagnosis on theoretic grounds. Of course, toxemia of pregnancy is frequently (15 to 40% incidence reported) associated with abruptio placentae and multiparity with placenta previa. Abnormal presentations have also been incriminated (15%) in placenta previa, but the important point to remember is that statistics are useless in diagnosing a particular case, although, if one plays percentages, his guesses will be more frequently correct.

Therefore, all bleeders should be admitted to the hospital. The obvious ones close to term with significant hemorrhage should be worked up immediately and when an evaluation of the patient's general condition can be made from careful examination of the vital signs, and the necessary laboratory work, a definitive diagnostic procedure should be done in the operating theatre with all means at hand to proceed to abdominal section should the situation require such a step. The case of the bleeders, prior to the 36th week of pregnancy, must be handled in a markedly different fashion. Macafee and Johnson, on different continents, published similar papers suggesting a method of management of bleeders in pregnancy who have not yet reached 36 weeks of gestation. This management has been labeled "the expectant management" and various clinics have reported a reduction of 25% in perinatal mortality for babies born associated with placenta previa.

The reasoning behind this management is simple:

1. It has been shown that babies born any

Presented at the meeting of the South Carolina Medical Association, April 27, 1961.

time after 36 weeks, weighing 2500 grams or more have as good survival figures as term babies.

2. Women with last trimester bleeding rarely, if ever, bleed to death with the first episode of bleeding unless subjected to a rectal or vaginal examination.
3. Blood replacement for the mother with a complication of placenta previa, and a premature infant, is feasible over a protracted period of time, and is instrumental in maintaining intra-uterine growth and development.

Once a decision has been made to manage a patient "expectantly" certain ancillary steps should be taken. A complete and frank discussion is indicated so that the patient understands the reasons for delay. Also an assessment of the patient's intelligence, should home care be necessary, must be made. Proximity to the hospital, an informed husband and an enlightened house staff are important facets to this complicated problem. Certainly a complete hospital workup is indicated at the time of the first bleeding episode. Such entities as blood dyscrasias, isoimmunization, blood type, and the level of hemoglobin and hematocrit must be screened and evaluated. A very gentle abdominal examination of the pregnant uterus should be done and the fetal heart rate carefully noted as well as the location of the placental bruit. At this time an evaluation of the size of the fetus should be made and correlated with the times of the last menstrual period and expected date of confinement. It is most important that accurate prenatal records be kept. The first time fetal heart tones are heard should be underscored on the record. This one sign can greatly ease the difficulty in evaluating the length of gestation since a twenty week period after the heart sounds are first audible guarantees a sufficiently mature infant.

If the initial bleeding has stopped or is just minimally present, a careful examination with the speculum is in order to rule out local factors which could cause bleeding. At this time, however, digital exploration of the fornices in order to evaluate the softening associated with placental implantation should not be done.

The patient should then have a placentogram performed. With modern techniques this exposure amounts to considerably less than 0.5 roentgens. No other examination, radioactive tracers included, can match the information obtainable on a good placentogram. Even posterior implantations can be detected if the technique is carefully followed, and the bowel free of air and contents.

The use of bladder contrast studies in my experience has not been significantly advantageous and displacements of the head frequently can be detected on the placentogram.

The important feature of a good placentogram is the finding of a fundal implantation. Although these cases are still obtuse because of their bleeding history, after this sign subsides, it is very comforting to know that as they leave the hospital still undelivered, they do not in fact have placenta previa. Since this is the worst offender, much confidence is gained as to the eventual outcome.

Other than weekly visits, blood replacement, serial blood level determinations and reassurance to the patient, nothing more should be done in cases of probable placenta previa until 36 to 37 weeks depending perhaps on the size of the fetus as determined abdominally. At this time with confidence in the maturity and prognosis of the fetus should it be removed from the uterus, a definitive examination is done in a room arranged for immediate laparotomy. Cross matched blood should be available and a large bore needle should be inserted in an arm vein with isotonic fluid running. A sterile vaginal examination is performed. First palpation of the fornices is done followed by digital exploration of the cervical canal and lower uterine segment.

Should placenta previa be diagnosed by palpation of the characteristic feel of trophoblastic tissue or heavy bleeding ensue, nothing is served by further conservatism and immediate low segment cesarean section should be performed. On the other hand if no tissue is felt, and no bleeding results, the patient can be observed for an additional hour or so and discharged to her home with instruction to return in one week, immediately if bleeding recurs, or with the onset of labor. At surgery in the case of placenta previa I have maintained the Munro-Kerr transverse incision in

the lower segment, and even in cases of anterior wall implantation of the placenta, my only modification is to reach into the uterus before delivery of the infant and extract and clamp the cord, thus preventing hemorrhage from occurring on the fetal side of the placenta. Several reports by Kistner and others having indicated that placenta accreta is more frequently associated with abnormal implantations, and in addition under direct vision through the incision in the lower segment better hemostasis can be achieved than can be expected through the classical incision. It is superfluous to mention the use of bag or pack.

Abruptio placentae is the other potentially catastrophic entity associated with third trimester bleeding. In this situation very little is served by the so called conservative approach, and in fact much harm can result. The incidence of abruptio is 0.5% and has been aptly called accidental bleeding of the last trimester as contrasted to placenta previa which is inevitable bleeding.

Arbitrarily this entity has been classified in this way:

1. Mild abruptio with external bleeding of less than 400 ml. with little pain, or hyperirritability of the uterus, and a normal fetal heart.
2. Moderate severe abruptio — external bleeding of more than 400 ml. with considerable more pain than is usually present, tense, irritable uterus and slow or irregular fetal heart.
3. Severe abruptio — hemorrhage or not associated with a tense painful uterus, absence of fetal heart sounds, and possibly associated with shock, or clotting element depression.

It is important to realize that there is only one entity present, premature separation of a normally implanted placenta. In my experience with placental anatomy and physiology, I have been unable to demonstrate the Spanner theory on the circulation of the placenta and must include the so-called "marginal sinus tear or bleeding" as a mild type of abruptio placentae.

The method of management is basically the single act of emptying the uterus although the method of delivery, vaginal or abdominal, depends on several variables. The immediate examination of the patient should be followed by a sterile vaginal examination with amniotomy. The rupturing of the membranes decreases the intra-ovular pressure which is said to decrease the possibility of extravasation of maternal blood into the surrounding tissue with subsequent failure of the clotting mechanisms. Also, of course, the placenta is splinted to a certain extent by this decrease in pressure. The labor is augmented, and this is desirable should the vaginal route be selected. Lastly, occult bleeding into the amniotic or chorionic sac can be immediately detected.

It is my conviction that many cases of abruptio placentae and placenta previa in mild forms can not be differentiated. Fortunately most abruptio cases occur after 36 weeks and can be immediately subjected to a double set-up procedure. Little is lost in the equivocal early abruptio by conservative management until one's hand is forced by hemorrhage or overt signs of uterine hyperirritability or fetal heart irregularity. Certain it is that the perinatal mortality, to say nothing of maternal mortality, can be reduced only by more rapid delivery which implies the abdominal route if much cervix is still present. In the mild cases of abruptio an attempt at vaginal delivery is in order and rupture of the membranes and oxytocin stimulation is permissible if the x-ray measurements of the pelvis are adequate.

All cases of abruptio with slow or irregular fetal hearts should be delivered promptly.

Finally a word about two complications which are not uncommonly seen with abruptio placentae.

(1) Renal shut down

Renal shut-down is frequently seen in neglected cases of abruption in which the patient was at some time in a shock state. Almost invariably these patients, because of prodromal symptoms, have became dehydrated in the preceding couple of days. If after delivery a careful observation is made on urine output before allowing dehydration or a hyperpotassemia from transfusions to occur, some reasonable success can be expected if the patient is not harmed iatrogenically.

(2) Hypofibrinogenemia

In our institution at Chapel Hill it has been

our policy in cases of abruptio placentae to evaluate carefully the mother's peripheral blood for clotting defects. The numerous factors besides fibrinogen, found in the prothrombin component such as A.H.F.., Hageman, Christmass, Factor V & VII, etc., can all be distorted in this type of bleeding. Although no specific remedies other than fresh blood or fibrinogen are available at this time, it is of some importance when fibrinogen can be given. Since fibrinogen is obtained from pooled plasma its use is complicated by homologous serum hepatitis in 8% of the cases. The use of fibrinogen prior to delivery of the fetus and placenta, theoretically at least, enhances intravascular thrombosis and emboli. It is probably better policy to deliver the patient by the most expeditious means, cesarean section included, and then after removal of the placenta invoke fibrinogen therapy. An intermediate road followed by some is to use whole fresh blood in the transfusion.

The danger associated with abruptio is too close adherence to the theorem of "delivery from below if at all possible". Probably all abruptio cases can be delivered from below but at such cost! Maternal and perinatal mortality is frequently associated with renal shut down, Couvelaire uterus and failure of the clotting mechanisms. A scar on the uterus is just not that bad in contrast.

Population studies of atherosclerosis. Dale Groom, M. D. (Charleston) Ann. Int. Med. 55:51-62, July 1961.

Studies of human populations have contributed impetus and unique insight to our understanding of atherosclerosis. They serve as nothing else can to delineate the natural history of the disease, often on a scale unprecedented in clinical medicine. Most important, they deal with the end results in the human.

On the other hand, certain limitations inherent in this approach account for many of the conflicting interpretations and conclusions. Population studies are fraught with an appalling number of variables, with barriers of language, medical customs, and understanding which become greater as greater becomes the contrast in civilizations. They are of necessity uncontrolled and lack the precision of the planned animal experiment.

Vital statistics of the medically underprivileged country are not an accurate measure of the prevalence of atherosclerosis and cannot be weighed against those of a highly civilized people. Largely on the basis of such statistics, the concept has grown that the high fat diets associated with an economy of abundance causes high levels of lipids in the blood which, in turn, cause occlusive disease in the intima of arteries. Though evidence is overwhelming that fat metabolism is intimately related to atherogenesis, a second look at the population data shows strikingly similar correlations with environmental factors other than diet (stress, educational standards, competitiveness and drive, use of tobacco or telephones, trace elements in drinking water, occupation, and physical exercise) as well as with race, gender, family history, and perhaps aberrations of blood clotting.

Generally the more objective studies of pathologic material show lesser differences in incidence and severity of atheromatous disease. Moreover they disclose significant patterns of localization of lesions among populations (and individuals), the reasons for which are unknown. We grow old at different rates in the different vascular beds of the body.

Re-operation for mitral stenosis by D. E. Harken, H. Black, W. J. Taylor, W. B. Thrower and L. B. Ellis (Charleston) Circulation 23:7-12, Jan. 1961.

A series of 80 re-operations for mitral stenosis in 79 patients is reported and analyzed.

The most important causes of deterioration after valvuloplasty for mitral stenosis are inadequate initial operation, re-stenosis, and mitral insufficiency. Generally more than one of these factors pertain.

An adequate mitral valvuloplasty requires the complete opening of both the anterior and posteromedial commissures and the mobilization of the chordae tendineae from each other and from the wall of the ventricle.

The advantages and limitations of closed re-operation, open re-operation, the right-sided approach, and the use of the transventricular valvulotome are reviewed.

More complete correction of stenosis with mobilization of posteromedial, anterior, and subvalvular chordae is emphasized. This is attained by operating from both the ventral and dorsal aspects of the patient through a left posterolateral thoracotomy incision.

An Ivalon operating tunnel sutured to the left atrial wall at re-operation makes it possible to carry out the more extensive valvuloplasty at re-operations.

A lower operative mortality, better longterm results, and fewer instances of deterioration are anticipated when this concept of improved valvuloplasty is effected initially.

MANAGEMENT OF ACUTE RENAL INSUFFICIENCY

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The author discusses the causes of this condition, e. g., acute tubular necrosis, and the basic pathologic changes, differential diagnosis, complications, and management —Cation exchange resins, peritoneal dialysis, and hemodialysis are considered.

Acute renal insufficiency, in the most literal sense, connotes cessation of urine flow secondary to disturbance in the normal physiology of the kidney and is thereby distinguished from anuria secondary to blockage of the ureters or lower urinary tract. Its causes are numerous and include acute tubular necrosis, renal medullary necrosis, bilateral renal cortical necrosis, and acute glomerulonephritis.

By far the most common cause of acute renal failure is acute tubular necrosis. I shall use acute tubular necrosis as a prototype in discussing acute renal failure, since the derangements produced by anuria of various causes are more or less the same. Although there had been previous references to the disease, it was not until the early years of the second World War that understanding of acute tubular necrosis began to advance rapidly. In 1941, Bywaters and Beall[1] described "crush injuries with impairment of renal function", which came to be called Lower Nephron Nephrosis by Lucké[2], because it was thought that the lesions causing anuria were in the distal tubule or "lower nephron".

A major advance in understanding the pathology of the disease was made in 1951 by Dr. Jean Oliver,[3] who dissected out entire nephrons from kidneys of patients with acute tubular necrosis. He pointed out that the lesions are not confined to the distal tubule, but, in fact, are scattered throughout the nephron. He found that there are two types of lesion: one, which he called the nephrotoxic lesion, is confined to the proximal tubule while the other, called tubulorrhexis, occurs in any part of the nephron. It is Dr. Oliver's contention that the latter-mentioned lesion is a consequence of ischemia, whereas the other lesion results from toxins.

Thus, in acute renal insufficiency of nontoxic origin, the insult is circulatory, a part of an episode in the general circulatory disturbance which has involved the peculiarly susceptible area of renal blood flow. Such a renal circulatory episode may occur also as a consequence of the circulatory disturbance of intoxication. These findings make it easier to understand why acute tubular necrosis may be produced by a variety of poisons and drugs, heavy metals, products of hemolysis and the crushing of tissues, or an episode of shock.

Differential Diagnosis

Prompt recognition of acute renal insufficiency is essential if proper management in the early days of the disease is to be afforded. The physician is frequently faced with the clinical problem of a patient who has been oliguric for a matter of hours arising from a situation that may have produced acute tubular necrosis, but, which, on the other hand, may be due solely to dehydration and hypovolemia. It should be emphasized that proper correction of dehydration should always be undertaken, but the practice of injudiciously administering "fluids" in an effort to "flush the kidneys" or in some hopeful but unrealistic manner to produce urine is hazardous and to be deplored.

In general the differential diagnosis of anuria is not easy, but if one approaches each case in some systematic fashion and with reasonable assurance about the disorders that must be excluded, the diagnosis can be established without doubt in the great majority of cases.

The diagnosis of acute tubular necrosis should not be accepted until (1) dehydration has been corrected and (2) there is no doubt

about lower urinary tract and ureteral obstruction.[4]

Lower urinary tract obstruction is excluded simply by the insertion of a catheter into the urinary bladder. Exclusion of ureteral obstruction is more complicated, obviously, but nevertheless, if the history does not point to an obvious diagnosis of acute tubular necrosis, it is our feeling that ureteral catheterization on one side, at least, should be undertaken. Furthermore, this procedure should always be preceded by a flat film of the abdomen in order to ascertain that both kidneys are present.

In addition, there are certain urinary findings which are characteristic of acute tubular necrosis. The urinary specific gravity is usually about 1.010 in tubular necrosis, whereas in dehydration or acute tubular necrosis it will be much higher. Further, although they are not conclusive, there are data which imply that the urinary Na concentration is high (80-110 mEq./L) in acute tubular necrosis, whereas in dehydration it will be extremely low.[5] Lastly, it is not uncommon for one to observe sheets of epithelial cells in the urine shortly after the onset of tubular necrosis.

The Pathophysiologic Consequences of Anuria

Once the diagnosis of acute tubular necrosis is made, it is imperative that one understand thoroughly the principles underlying management. As Merrill has written,[6] "It cannot be said that this is a disease from which the patient usually recovers in spite of the physician. Rather it is a disease of which patients frequently die because of mismanagement."

It therefore seems worthwhile to discuss briefly the pathophysiologic consequences of anuria.

Most of the chemical derangements result from a lack of excretion of the end products of protein metabolism. The blood urea nitrogen concentration progressively increases as anuria proceeds; however, so far as is known, increase in urea concentration to the extent seen in acute renal failure, produces few, if any, deleterious effects but serves rather as a parameter of protein catabolism and retention of other substances which are toxic. As the blood urea nitrogen concentration rises, nausea and vomiting become prominent, bleeding disturbances appear, and anemia which results from both bone marrow depression and increased destruction of erythrocytes becomes established. Although the data are not clear-cut, there is abundant evidence that decreased resistance to infection and delayed wound healing are consequences of anuria. In fact, one of the leading causes of death in acute renal insufficiency nowadays is infection.

The most serious and life-threatening abnormality that results from inability to excrete protein breakdown products is the development of hyperkalemia; however, this complication is not as common as formerly, as will be discussed later.

Still another consequence of retention of end products of protein metabolism is the increase in the concentrations of phosphate, sulfate, and other non-volatile anions. The increase in concentration of these acids has at least two secondary consequences. *First*, since they are buffered by the bicarbonate-carbonic acid pair of buffers, they are more highly dissociated acids than carbonic acid. As a consequence there is a reduction in the concentration of bicarbonate, an increase in the concentration of carbonic acid and pCO_2, and a decrease in the pH. The two latter alterations stimulate increased respiratory effort. The excretion of CO_2 by the lungs is accelerated, and the metabolic acidosis may become reasonably well compensated. *Second*, the increased concentration of phosphorus is associated with the development of hypocalemia which rarely may cause frank tetany.

In addition to lack of excretion of protein breakdown products, there is no excretion of water and there are several areas in which water retention can lead to dire situations.

First and foremost is congestive heart failure, particularly acute pulmonary edema. This is not as common a complication as formerly because, as we have learned more about acute tubular necrosis, we have learned that the water requirements of these patients are not as high as was formerly thought to be the case.

Secondly, water retention leads to hyponatremia and hypotonicity of the extracellular fluid so that water tends to enter cells and the consequences of water intoxication; convul-

sions, weakness, apathy, and mental obtundity become manifest.

As stated earlier, it is essential that management of anuria be based on sound physiological principles because the patient's survival is largely dependent upon proper management. Careful attention to details in the care of the seriously ill patient should not be overshadowed by attention to electrolytes, etc.

In establishing the water needs of the patient, the best guides are the daily weight of the patient and careful observation of the amount and character of output from all routes. The physician must not allow the patient's appreciation of thirst and hunger to dictate the therapy, but, instead, he must control in entirety the patient's intake.

A non-febrile 70 kg. patient resting in a temperate environment and not sweating has an insensible loss of water from skin and lungs amounting roughly to 1000 ml. per day. Preformed water and water of oxidation of fat and protein should amount to about 400-500 ml./day, thus leaving a water deficit of 500-600 ml./day.

Endogenous protein catabolism in such a resting patient receiving no exogenous nutriment amounts to approximately 1 gm. per kilogram of body weight—or about 70 gm./day in a 70 kg. man.[7] This protein catabolism will be increased by fever, infection, physical activity, and the so-called metabolic response to injury in postoperative or post-traumatic cases. Measures which minimize these factors will retard the development of potassium intoxication and acidosis.

Since the remainder of the caloric requirement must be met by burning body fat, there will be a tendency towards ketosis which will increase the acidosis related to the retention of the inorganic anions sulphate, phosphate, etc.

This may be combatted by the administration of 100 gm. of carbohydrate per day. Not only will this prevent ketosis, but will reduce protein catabolism by elimination of protein contribution to the Krebs cycle. Thus the rate of accumulation of sulphate, phosphate, potassium, and urea will be decreased.

To recapitulate, the patient without complicating features should receive about 500 ml. water and 100 gm. carbohydrate per day. It is our practice to administer this by way of a plastic catheter inserted in a peripheral vein and extended into the vena cava. A 20% dextrose solution administered throughout the 24 hours is a satisfactory fluid prescription. Further, we usually do not allow the patient to take anything by mouth because of the high incidence of vomiting, and we have observed both aspiration and cardiac arrhythmias complicating vomiting.

It is the rare case that can be managed by proper fluid and caloric intake alone, and there are other measures that almost always must be employed.

In the first place, most patients with acute tubular necrosis exhibit marked protein catabolism in the first few days of anuria. This is most severe, of course, in post-traumatic and post-surgical uses. Hyperkalemia in these instances is rarely controlled without application of other measures. And, furthermore, when anuria lasts more than 10 to 14 days, and, in some cases even before this, patients become less alert, more prone to convulsions, and even progress to coma. Although the cause for this mental deterioration is unknown, it is thought to be secondary to retention of some as yet unidentified toxic substances.

It is because of these phenomena that other measures are necessarily employed, notably cation exchange resins, "anabolic" agents, and dialysis, both peritoneal dialysis and hemodialysis.

Cation Exchange Resins

These agents have come to be used more and more in controlling hyperkalemia and consonant with their wider use, better resins have been developed. An ion-exchange resin is a cross-linked polymer containing acidic or basic structural ions that can exchange either cations or anions respectively on contact with a solution.

In general, resins that are useful in combatting hyperkalemia are in the sodium, hydrogen, or ammonium cycle. In most circumstances resins in the sodium cycle are preferable to those in the hydrogen or ammonium cycle since the latter two will produce metabolic acidosis and tend to offset the beneficial effects of removing potassium, since acidosis *per se* may produce hyperkalemia.

The resins may be administered orally or rectally. We have found administration by the rectal route to be more satisfactory since patients with acute renal insufficiency tend towards nausea and vomiting and the resins are quite unpalatable. Furthermore, the fluids of the lower gastro-intestinal tract are rich in potassium.

Recently a new sodium-exchange resin has been developed which is more palatable and which moves more easily through the gastro-intestinal tract. This resin is a sulfonic polystyrene cation-exchange resin in the sodium cycle.

It is difficult to be sure of the correct amount of resin to use in any case. It has been our practice to administer 20 gm. by rectum every 1 or 2 hours until the serum potassium concentration is within normal limits and then to continue resins at regular intervals, the frequency of which is dictated by effectiveness in maintaining the serum potassium at normal levels.

Another maneuver which we have found effective in reducing serum potassium concentration as well as ridding the patient of excess water has been the administration of Sorbitol, which is a non-absorbable polyalcohol of the hexose sugar sorbose. Sorbitol, since it is not absorbed from the gastro-intestinal tract, is an osmotic cathartic and removes water as well as potassium and other electrolytes.

Peritoneal dialysis—Although this procedure was first used in human subjects in 1923, it had never been widely employed in treating patients with acute tubular necrosis, probably because of complications accompanying its use. However, in the past few years the technique has been improved so that the incidence of complications is low.

It has been our experience that peritoneal dialysis is quite beneficial in correcting the chemical abnormalities of anuria, but that it accomplishes little in correcting the mental obtundity and other symptoms which accompany anuria, but which cannot be relieved by correcting the chemical abnormalities.

For these reasons, it has been our practice to employ peritoneal dialysis in those situations in which the patient is reasonably alert but in whom hyperkalemia and acidosis cannot be controlled by the measures which I have previously mentioned.

Hemodialysis—During the past 10-12 years there has accumulated a large body of evidence that has resulted in agreement that hemodialysis is a necessary concomitant to the conservative management of acute renal insufficiency. There is little doubt that hemodialysis has been life-saving in certain instances where other measures failed, and there is now abundant evidence that hemodialysis decreases the morbidity and incidence of complications in acute renal insufficiency.

As experience with the artificial kidney has broadened, there have been changing concepts as to the indications for its use. The tendency in most centers seems to be use of hemodialysis earlier in the course of acute renal insufficiency. However, the indications still range from those which are clear-cut and agreed upon to those which are vague and in dispute.

The most notable and unchanging indication for hemodialysis is uncontrollable hyperkalemia. Hemodialysis is unsurpassed in the rapidity and certainty with which the extracellular concentration of potassium may be decreased. However, coincident with the aggressive use of cation exchange resins and peritoneal dialysis, the incidence of hyperkalemia has been markedly reduced so that this is not a common indication for hemodialysis.

Other chemical derangements such as extreme elevations in blood urea nitrogen and marked acidosis in themselves are often considered in some centers as indications for dialyses, and, because extracellular fluid is effectively removed by machines employing ultrafiltration, marked overhydration, when resulting in symptoms of water intoxication or cardiac failure, might be considered at times as an indication for hemodialysis.

It has become increasingly apparent to those treating acute renal insufficiency that lowering the serum potassium to normal, as well as correcting acidosis and other electrolyte derangements, does not uniformly prevent clinical deterioration as manifested by mental obtundity, twitching, convulsions, and coma. Furthermore, there is not always good correlation between the appearance of these symptoms and

the concentration of blood urea nitrogen.

For these reasons, clinical deterioration of the patient rather than chemical abnormalities *per se* has become a major indication for hemodialysis. At present the ease of decision to dialyze is directly dependent upon the rigidity of criteria used to make the decision.

Recently there have been reports[8, 9] advocating repeated prophylactic dialyses as a means of preventing clinical deterioration, and, in fact, practically all of the consequences of anuria. In one of these reports[9] there was noted an impressive decrease in mortality rate as well as complications.

It should be emphasized, however, that this means of treating acute renal insufficiency has not been employed widely. Since it is quite expensive and requires large numbers of skilled personnel, its efficacy should be established before it is undertaken on a widespread scale.

Management During the Diuretic Phase

The diuretic phase of acute renal insufficiency is characterized by output of large volumes of urine which is hypotonic. The kidneys, during this stage, are also not able to conserve solute. Therefore, the outstanding dangers during this phase are extreme dehydration and subsequent vascular collapse hypokalemia, hyponatremia, and acidosis.

It is necessary during this period to know accurately the patient's state of hydration, the urinary output, as well as the urinary concentration of sodium and potassium, and the serum sodium, potassium, and bicarbonate concentration. When these parameters are known, one can replace accurately the losses of water and solute.

In closing, I should like to comment on another—and perhaps the most important—aspect of the management of acute renal insufficiency. In the preceding remarks I have tried to emphasize that the great majority of patients will require specialized forms of therapy that by economic necessity are available only in hospitals wherein a larger number of patients with acute renal failure are seen. Further, it is highly improbable that one can predict at the onset of the disease which patients will need these therapeutic adjuncts or when diuresis will ensue in any given patient. For these reasons, it is our philosophy that once the diagnosis is made or suspected the patient should be sent to a hospital where all the necessary chemical measurements can be made and all the highly specialized forms of therapy are available.

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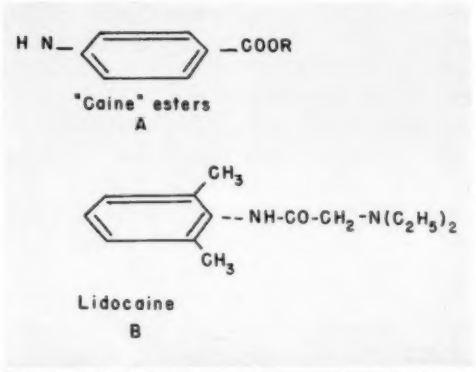
A NEW ANTI-INFLAMMATORY ANAESTHETIC TOPICAL PREPARATION*

A. M. ROBINSON, M. D.
Columbia, South Carolina

Topical anaesthetics have long been used to relieve itching; however, their chief drawback has been contact sensitivities particularly from the esters of para amino benzoic acid (A) often referred to as the "caines". Procaine and benzocaine are examples of these frequent sensitizing agents.

Lidocaine (xylocaine) is a totally different molecule. It is not a "reactive" ester but a stable amide of xylene (B)

Thus lidocaine has been erroneously named and should not be classed with the sensitizing "caine" drugs.[1]



Freeman[2] used lidocaine in the Acid Mantle base** and found it beneficial in 50 cases of pruritic dermatoses. No cases of sensitivity were found. This preparation was further in-

*Lida-Mantle HC, Dome Chemicals, Inc., New York, N. Y.

TABLE 1

Condition	Number of Cases	Results ++++	+++	++	0
Nummular Eczema	6	2	4		
Hypostatic Eczema	1		1		
Contact Dermatitis	2	1	1		
External Irritative Dermatitis	2	1		1	
Intertrigo	2			2	
Atopic Dermatitis	2	1		1	
Neurodermatitis	3	1	1		1
Xeroderma	2		2		
Lichen Planus	1		1		
Lichen Chronicus	1			1	
Psoriasis	2		2		
Pruritus	6	1	5		
Scalp	2	1	1		
Ani	2		2		
Vulvae	2		2		
Herpes Progenitalis	1	1			
Total	37	9	22	5	1

Responses—++++ - Excellent; +++ - Good to excellent; ++ - Fair to good; 0 - Poor

corporated with hydrocortisone (Lida-Mantle HC)* and studied by your author in a variety of dermatoses (Table 1). Thirty-one patients applied the creme, usually twice daily for two to three weeks. Twenty-five experienced good to excellent results. One patient experienced poor results. No evidence of sensitivity was noted. All patients liked the spread and cosmetic character of the preparation.

The advent of effective anti-inflammatory antipruritic combinations are welcome additions to physicians' arsenals of therapeutics. However, the search for etiology or causations should never be relaxed by the physician even if the patient is afforded relief.

Summary—A new combination creme of hydrocortisone and topical anaesthetic lidocaine in the Acid Mantle base** has proved beneficial in thirty cases of varied dermatosis which are often resistant to topical hydrocortisone or anaesthetics alone.

*Lida-Mantle HC, Dome Chemicals, Inc., New York, N. Y.

**Lida-Mantle, Dome Chemicals, Inc., New York, N. Y.

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MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

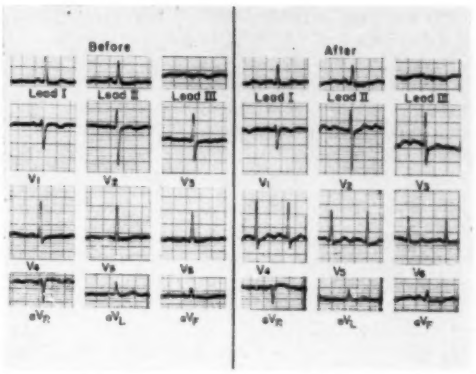
ELECTROCARDIOGRAM OF THE MONTH

T-Wave Disease

DALE GROOM, M. D.
Department of Medicine

Case Record—During a particularly stressful week of activity a 35 year old lady complained of a vague discomfort in her mid-chest with paresthesias, weakness and giddiness. She was examined by a physician who, according to her, mentioned heart disease among several possible causes and advised rest.

Her symptoms and anxiety increased over the ensuing months and she consulted several other physicians, had many electrocardiograms and laboratory tests. On one occasion she was admitted to a hospital where a borderline value of serum transaminase was reported (following, however, an injection of Demarol). No clear-cut diagnosis of heart disease was ever established but there was some divergence of medical opinion pro and con despite a very thorough cardiac evaluation which was negative. Invariably the patient herself seized upon whatever suggestions and measures pertained to organic illness, so that ultimately she acquired a regimen of continuous anticoagulant therapy, nitroglycerin and rigid restriction of physical activity which she followed carefully for more than two years without improvement.



As the anxiety of the patient and her husband mounted her symptoms multiplied to include those of aerophagia, postural hypotension, and a sense of shortness of breath with dizzy spells, all characteristically worse during the premenstrual week and at times of fatigue or stress. Finally she was again told that her symptoms were functional and the anticoagulant therapy was discontinued, whereupon she became mildly depressed.

A review of her voluminous medical records over this three year period uncovered no objective evidence of cardiac abnormality other than various T-wave changes of a non-specific nature and sagging of S-T

segments with no more than 0.5 mm. depression in precordial leads following an exercise test.

Complete cardiac examination was negative as were barium studies of the esophagus and stomach. The blood levels of cholesterol, calcium, proteins, sugar, sodium, chlorides and potassium were within normal limits. Psychiatric opinion characterized her illness as one of considerable anxiety and depression in a basically obsessive-compulsive type of personality.

The patient's exercise tolerance was observed to be excellent in the performance of double the usual amount of exertion of a Master test. These tracings were made before and immediately after the exercise. *Electrocardiograms*—The resting tracing is normal except for flattened, diphasic or inverted T waves in several leads.

Following exercise the Q-T interval (best measured in lead I) decreases commensurate with the increase of rate to 120, U waves become quite prominent in most precordial leads where there is minimal depression of S-T segments and the T waves actually change in the direction of normal, becoming more upright.

Discussion: What might justifiably be called "T wave disease" is the familiar sequence of events typified above, stemming from a few symptoms plus an electrocardiogram showing various T wave changes of a non-specific nature. Too frequently in past years ECG diagnoses of "myocarditis" or "myocardial damage," based on such tenuous evidence, focussed unwarranted anxiety on the cardiovascular system and sometimes made invalids of physically normal individuals. Probably no subject in electrocardiography is as controversial as this but with the more recent insight into repolarization—and particularly with recognition of the effects of autonomic and electrolyte factors on it—the numerous functional aberrations of T waves are being more readily differentiated from those due to organic heart disease.

The T wave is at the same time the most sensitive indication of myocardial abnormality and the most capricious of the electrocardiographic complexes. It is of course markedly altered by certain drugs, (e. g., digitalis, quinidine, probanthine, emetine), by endocrine and electrolyte (especially potassium and sodium) changes. Autonomic stimulation can in some individuals significantly affect conduction (P-R interval) as well as repolarization. The influence of physical factors is illustrated in the classic experiment of Wilson demonstrating actual T wave inversion in normal subjects after drinking ice water. A few adults for some reason retain the diphasic or inverted T waves of childhood (the "retained juvenile pattern"), while others show marked ECG changes in different phases of respiration or following a full meal or on going from the supine to the erect position. The particular type of T wave variation seen in this patient has been ascribed to a shift of potassium across the cell membrane in response to stress. All these factors can operate independently of any coronary or myocardial disease.

Against a diagnosis of coronary insufficiency here is the absence of any abnormality in the QRS complexes or in atrial conduction, the unchanging pattern in the patient's many electrocardiograms over a three year period and of course the rather atypical nature of her symptoms and their obvious focus on cardiac action. Admittedly her anxiety might well have become focussed on the gastrointestinal or reproductive system had it not been for the T waves but certainly the repeated examinations and tracings, the anticoagulant regimen with weekly prothrombin time tests, the imposed restriction of activities, and the opposing medical opinions very effectively fostered the functional illness.

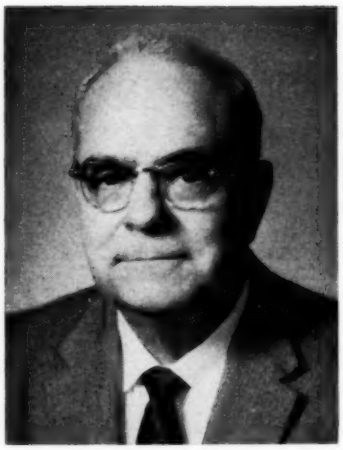
To some patients the electrocardiograph must be little short of a magic machine pouring out oracles with every lead.

Observations on digitalis intoxication—P. L. Rodensky and F. Wasserman. Arch Intern Med. 108:171 (Aug.) 1961.

To study the various facets of an apparent increase in the incidence of digitalis cardiotoxicity, a 1-year, preplanned study was undertaken in a general medical hospital. Assessment of the total clinical situation in each patient was critically important for establishing the proper diagnosis. Rapid diureses, failure to individualize digitalis dosage, and attempts at short-cuts in therapy precipitated many of the 92 separate episodes of digitalis intoxication observed in the 88 patients studied. Thirty-one patients developed cardiotoxicity while receiving digitalis combined with chlorothiazide or hydrochlorothiazide. An active myocardial process, chronic lung disease, chronic renal disease, electrolyte imbalance, and various forms of heart disease served as predisposing factors. Withdrawal of digitalis and oral or intravenous administration of potassium chloride proved efficacious in treating most digitalis-induced ectopic rhythms. The over-all mortality was 28%, with 11% of deaths resulting solely from digitalis overdosage.

Chromic phosphate disappearance in cirrhosis of the liver and congestive heart failure. Cheves McC. Smythe, M. D. (Charleston). J. Lab. & Clin. Med. 57:927-937, June 1961.

Disappearance rates of colloidal chromic phosphate in patients with cirrhosis of the liver, congestive heart failure, and miscellaneous diseases of the hepatobiliary system have been compared with those in normals. When these disappearance constants are used for calculation of hepatic blood flow, rates of flow approximating those obtained by other methods are found in normal individuals. There was no change of disappearance rates in the presence of severe hepatocellular disease. Other variables must be involved in determining colloid disappearance rates which might invalidate their use for studying hepatic perfusion in clinical hepatocellular disease.



President's Page

With all the fall and winter holidays coming on, it was very befitting that the Governor should call a meeting on Highway Safety in Columbia on September 19. Certainly such a meeting is past due in this state, and it is very fortunate, too, that the State Medical Society has already gotten its house in order, to help and work with the Governor in the promotion of this phase of reducing the death toll on the highways of this state. A very excellent report was rendered to the House of Delegates of the Association last April in Charleston. At that time the Committee recommended the use of seat belts, and that the recommendation be made through the proper channels to the automobile manufacturers that seat belts be placed on all late model cars at the assembly plants. A similar recommendation was made at the AMA meeting in New York this past June.

It seems that the idea has or is beginning to take hold all over the nation. Recently it has been noted that several states have placed these seat belts on all motor vehicles operated by the various states, and just within the past few days, that the State Highway Department has announced that just such a step would be taken here in South Carolina.

It is estimated that with the use of seat belts, that approximately 5000 lives may be saved annually, and that the injuries incurred in automobile accidents may be reduced by many thousands. These figures were given by Dr. Luther L. Terry, the Surgeon General of the Public Health, and seem to be very conservative. To those of us that have seat belts and use them, it is a very comforting feeling to know that you have a better chance of survival, if you should be involved in an accident, and certainly a doctor in his rounds of work is very vulnerable. If you are not one of those having this safety feature in your car, you should look into the matter.

Charles N. Wyatt

Editorials

FOUNDERS' DAY IS HERE AGAIN

That venerable institution, Founders' Day at the Medical College, will be held on November 2 and 3, when a large attendance is expected in Charleston.

Founders' Day was inaugurated by Dr. Robert Wilson in 1934, and was then a one day session which included a number of clinical presentations and a banquet garnished with some prominent speaker. In 1942 the meeting was expanded to three days' duration and was arranged, organized and financed by the Alumni Association, at that time under the enthusiastic presidency of Dr. James Fouché of Columbia. The Association continued to support and produce this "refresher course" for a number of years until the Medical College offered to resume its costs and management.

This session offers an excellent program, available to all the doctors of the state, or others interested. A full program is to be found elsewhere in this issue of *The Journal.*

DISASTER MEDICAL CARE

A Committee on Disaster Medical Care was recently appointed by the South Carolina Medical Association in convention. This committee consists of five members from throughout the state, all having shown previous interest in Civil Defense matters on a local or state level. The Committee has the purpose of increasing and encouraging medical efforts along civil defense lines, informing the profession of these efforts and soliciting their cooperation as well as keeping them abreast of new developments and recommended procedures, and coordinating these efforts with the national and state civil defense programs. In furthering this purpose several meetings have been held with state civil defense officials, and several recommendations have been made to the Executive Council of the Society.

It seems a definite likelihood, in view of world situations, particularly the Berlin crisis and Soviet resumption of atmospheric nuclear testing, that an atomic disaster might indeed occur, either by intent or accident. Should such occur in a well prepared area the results would be disastrous, but should it occur in an unprepared area any survival would be extremely unlikely. Our state is grossly unprepared for such an eventuality. Marked but somewhat belated efforts are now being made to increase our preparedness. The survival of our society in an atomic disaster depends to a large extent upon the preparedness of our physicians and related health groups. Each of us would undoubtedly do all in our power to help our communities and state in a disaster, but unless we are cognizant beforehand of the proper procedures to follow in case of a disaster of this type, our efforts will be largely futile and quite possibly even damaging.

In an effort to increase our preparedness, your Disaster Medical Care Committee in cooperation with the State Civil Defense Agency and Dr. J. I. Waring, Editor of the Journal, begins with this issue a series of articles elucidating medical preparedness. It is hoped that each physician will read these articles, as our joint preparedness for survival depends upon our being individually informed.

Raymond E. Ackerman, M. D., Chm.
Robert S. Solomon, M. D.
Charles R. May, M. D.
William C. Herbert, M. D.
J. Graham Shaw, M. D.

FLU TO YOU

Dr. Luther L. Terry, Surgeon General of the Public Health Service, who is undoubtedly cognizant of the many unpleasant possibilities facing the world in the not too distant future, adds another note of gloom by predicting that there is likely to be an upswing in the influenza cycle which will hit this country during the fall and winter. For this particular threat to our lives and happiness he offers a strong piece of advice that those persons in

certain groups take the influenza vaccine, now well established as effectual, in order to avoid the mortality which influenza might cause directly or as a trigger.

Last winter in England flu caused more than 1,000 deaths and was indirectly the cause of several more thousands. While anyone may be susceptible, Dr. Terry points out that the greatest danger is for those people who have heart disease, pulmonary disease, diabetes or other chronic illnesses, persons over 65, and pregnant women.

Once influenza strikes a community it is too late to protect the high risk groups. Therefore the propitious time for the use of vaccination is now.

THE TWO EDGED SWORDS

During recent years two groups of drugs have appeared which are of special interest to the surgeon. Their claim to interest lies in the fact that they add to the hazards of any operative procedure in patients who have been taking them.

One of these is the steroid group. Most surgeons have been the victims of the complications which may result from the administration of these drugs. Wounds which would be expected to heal promptly remain in a state of suspended activity and are highly susceptible to separation. Overwhelming infections occur with insidious silence but when detected are frightening and uncontrollable. Sloughs reminiscent of the textbook pictures of noma occur and treatment is of no avail.

Another well known danger which results from the administration of these drugs is the hypotensive state which may appear during anaesthesia. This hypotension is very difficult to correct. It is true that measures which prevent the occurrence of this hypotension should be instituted before anaesthesia is attempted but these measures entail giving more of the same or similar drugs. This fact puts the surgeon between the Scylla of hypotension and the Charybdis of nomadic slough, overwhelming infection and wound dehiscence. These statements may seem to have the taint of exaggeration but I do not believe that any surgeon who has been confronted with one of these nightmares would think so.

The next and most recent addition to the list are the group of reserpines, rauwolfias, and their cousins, the "tranquilizers". A veritable galaxy of these drugs has appeared and the list increases at such a rate that to keep up with the names taxes the memory of persons with total recall. They present a hazard to the surgeon in two directions. First, they are capable of inducing a hypotensive state during anaesthesia which is very refractory. This danger can be reduced if they are discontinued for ten days to two weeks prior to operation but the patient confronted with an emergency has the risk of his operation compounded. Second, these drugs have a dramatic hypotensive effect if given postoperatively in an effort to combat nausea, particularly in the patients on the borderline of shock. Again we have the Scylla of hypotension and the Charybdis of an "untranquil" state or nausea.

The moral of these remarks for the surgeon is that he be alert in his investigation of his patient to determine the administration of these drugs so that he may lay the blanket of protection about him more adequately. There is also a moral for the practitioner responsible for the giving of these medications. He should be keenly aware that they are two-edged swords, as are all drugs, but the effect of these on a surgical procedure can be especially disastrous.

George T. McCutchen, M. D.

A REPORT TWO YEARS FOLLOWING THE CREATION OF A CHAIR OF GENERAL PRACTICE AT THE MEDICAL COLLEGE OF SOUTH CAROLINA

GEORGE G. DURST, M. D.
PROFESSOR OF GENERAL PRACTICE
MEDICAL COLLEGE OF SOUTH CAROLINA

1. *Background and Preliminary Action.*

The historical cycle of developments in the realm of scientific medicine and medical education in the twentieth century is well known and requires no repetition. One need only comment that rapid developments in the medical sciences led to the evolution of specialties and sub-specialties to the point where medical school faculties became made up exclusively of men who had sharply limited their fields of interest. This historical cycle has been completed now with the realization by many leaders of the medical profession that medical education had gotten out of balance when during a student's entire course of studies, he had no contact with a general practitioner representing to him this important segment of the medical profession. Many of these leaders, during the past several years, have written and spoken of their concern about this situation.[1-9]

It has been pointed out that the pure logistics of bringing to the public adequate medical care will continue to require physicians who are engaged in general practice. This need is not only in rural or sparsely settled areas but has also been sharply demonstrated in certain congested areas where over-specialization has resulted in instances wherein the public has felt itself at a loss to secure basic medical care.

These factors have been recognized and, to help bring a balance into medical education, several medical schools, including the Medical College of South Carolina, have created departments or sections of general practice. This is a report on the creation of the faculty position of Professor of General Practice at the Medical College of South Carolina and the related activities during the first two years.

The following are quotations taken from letters written by the President of the Medical College of South Carolina announcing the creation of a Chair of General Practice in this school and answering specific questions asked by a newspaper reporter. These extracts reveal the ideas held at the inception of this program. " . . . at its meeting on March 26, 1959, the Board of Trustees of the Medical College of South Carolina established the new position of 'Professor of General Practice,' . . . . This professorship is established . . . on a part time basis. . . . a separate department of general practice has not been set up, at least for the present. The appointment is within the department of medicine, and I am sure . . . will develop . . . in cooperation with and support of that department. Although this medical school aims primarily at the preparation for general practice, assuming that any specialization will be undertaken by graduates as they may choose, heretofore there has been no defined area called 'General Practice' nor any title of that connection given."[10,11]

2. *Activities.*

The following report was prepared by the Professor of General Practice and, having been approved in principle by the President of the college, was used as a basic statement of intent at the time of the announcement of the creation of this position:

"Announcement and a Statement of Intent.

"The Board of Trustees of the Medical College of South Carolina at its meeting on March 26, 1959 created, upon the recommendation of the President, the new faculty position of Professor of General Practice. The action thus taken gives a more formal recognition of the traditional importance this school has placed in the development of men interested in and qualified to enter into general practice.

"It is well understood and accepted that the complex scientific advances in the various fields of medicine require that these be taught by men who by specialization have largely limited their interests and their professional contacts to certain specific areas of medical science.

"Conversely the general practitioner by virtue of his intimate and long contacts with the home, family and community backgrounds of his patients (often including several generations of a single family) is perhaps best qualified to teach the students the ethical principles and some of the art of applying this scientific knowledge to the individual patients as seen in day to day practice.

"Practical topics for discussion include the following:

(1) Selection of a location.
(2) Selection of an office.
(3) Office plans and equipment.
(4) Partnership arrangements.
(5) Office assistants.
(6) Records.
(7) Fees, billing procedures and policies.
(8) General business and financial aspects.
(9) Relations with other physicians and clinics.
(10) Relations with hospitals and nurses.
(11) Relations with pharmacists and drug stores.
(12) Relations with patients and their families.
(13) Office visits.
(14) House calls.
(15) Medical bag contents.
(16) Handling telephone calls.
(17) Handling the streetcorner and cocktail party 'patient'.
(18) Recognizing and dealing with the drug addict.
(19) Possible malpractice suits.
(20) Cases involving possible litigations.

(21) Handling insurance forms.
(22) Referral of patients to governmental or charitable institutions to which they are entitled for care.
(23) Handling the terminal patient and his family.
(24) Demeanor and comfort to family at the death of a patient.
(25) Professional organizations and postgraduate studies.
(26) General community and civic responsibilities.

"The future specialist as well as the future general practitioner needs to become acquainted with the viewpoint and some of the rewards to be expected in general practice. The Professor of General Practice will stress to the student that the most effective application of modern medical science requires teamwork. Each member of the medical team must have a clear conception of his position and a proper respect for the other members of the team.

"The general practitioner's position is in the first line of defense. He should be supported by a team of well qualified specialists who will assist in the care or take charge of complicated cases when requested. The general practitioner should feel no hesitancy in seeking the assistance of the specialist, and the specialist should welcome assistance from the general practitioner in caring for his patients.

"The Professor of General Practice as an advisor to the students, and to the interns and residents, will assist them as they plan their training and postgraduate studies. It is hoped that some of his enthusiasm and respect for general practice will be transmitted to them.

"It is expected that the Professor of General Practice will maintain a close liaison with the general practitioners throughout the state and that they will consider him as their representative in the faculty of the Medical College. In this manner it is anticipated that this position will assist in the public relations between the Medical College and the Medical College Hospital and the general practitioners of the state."

It was desired early in the development of this program to make it clear to the curriculum committee and the other members of the faculty that the Professor of General Practice had no desire to invade areas of instruction that were already being covered. A copy of this basic statement of intent was sent with a letter requesting comments and suggestions to the members of the faculty to inform them of the thinking on this matter and to elicit their understanding, cooperation, and assistance. The response to this was both gratifying and helpful in that there was generous approval of the ideas expressed and many additional useful suggestions were made.

The program for the students has been developed with deliberation and a keen awareness of the value of the medical students' time.

The Professor of General Practice has been one of twelve department and section heads to speak to the first year medical students in the series of lectures on "Clinical Correlation". The one hour lecture emphasized medicine as a profession requiring dedication, personal character and dignity, and high ethical standards. Orientation of the student and the physician within the profession was discussed.

The Professor of General Practice has been given the responsibility for the course on medical ethics for the second year medical students. This course begins at the time the students have their first contact with patients in the clinics and hospitals. Their studies of medical science which heretofore have dealt with test tubes and laboratory animals now have introduced the human factor and at this point much emphasis on ethics is in order.

This eight hour series of lectures is based on *Principles of Medical Ethics, Opinions and Reports of the Judicial Council of the American Medical Association.* Specific examples, actual or hypothetical, are used to illustrate the principles of medical ethics.

The following statement is quoted from the Medical College Catalogue for the year 1960-61: "General Practice—Instruction is given in the fourth year in the art and ethics of applying the principles of scientific medicine in general office, home, and hospital practice. Discussions are held on the selection of a location, partnership arrangement, building a practice, office management, and professional and personal financial planning".

The six lectures in this series are designed to invite attention to problems that may arise as one enters practice and to suggest courses of action which may be helpful. Much of the material discussed is illustrated by specific instances of actual experiences with patients. The business side of medicine is illustrated by reference to actual office records. A guest speaker with an outstanding reputation in organized medicine has been invited under the auspices of this course and has addressed the students on medical organizations and the importance of participation in their functions.

The Professor of General Practice has in addition to his normal teaching schedule participated as a member of several panel discussions.

3. *Accomplishments.*

The time is short for an evaluation of accomplishments. It does appear, however, that the action of the board of trustees in creating this faculty position, and in this manner giving formal recognition to the place of the general practitioner as an important member of the medical team, was in itself an accomplishment.

It is believed that this program helps to give the students better orientation within their profession. This is certainly needed by the future specialists as well as by those who plan to go into general practice.

The number of students who have requested conferences and guidance counselling concerning their future plans has been encouraging and especially en-

couraging has been the number who have indicated a desire to go into general practice.

The Professor of General Practice, as a member of the continuation education committee of the Medical College, has had special opportunities. He has served as a representative of the general practitioners of the state to the members of the faculty of the Medical College, and in turn as a spokesman for the faculty to the general practitioners. In this manner he has taken an active part in the public relations of the school and the Medical College Hospital.

4. *Planning.*

A. Preceptorships: The students of the Medical College of South Carolina have for many years held preceptorships on an informal basis. There is under study now a plan to have the Medical College cooperate with the committee on education of the South Carolina Chapter of the American Academy of General Practice to make preceptorship training more readily available.

B. General Practice Internships: The American Academy of General Practice proposals for internship and residency training in general practice have been under sympathetic consideration but have not as yet been implemented in the hospitals affiliated with this school.

C. General Practice Clinics: A General Practice or Family Clinic as conducted in connection with some schools has been studied. At the present time it is not considered that the clinical material here, although impressive in amount and variety, lends itself well to being separated into any group or groups similating in any real manner what one might expect to see in general practice.

The emergency room service here does give excellent experience in acute illness and traumatic cases.

Thought has been given to the possible value of the Student Health Service as a source of material somewhat resembling what may be seen in a general practice.

5. *Conclusions.*

Basic logistical considerations make it obvious that the general practitioner will remain the backbone of the medical profession during the predictable future.

A. It is proper that the highly specialized areas of scientific medicine be taught by those who, by specialization, have limited their spheres of interest. A medical school faculty should include one or more general practitioners as representatives of this important segment of the medical profession. This affords the student, both the future specialist and the general practitioner, in his formative years, an opportunity to gain a more complete picture of his profession and better orientation within his profession.

B. The general practitioner on a medical school faculty has a proper sphere of influence in teaching the art, ethics, public relations, and financial aspects of the medical profession.

C. The general practitioner on a medical school faculty has an important public relations role as a representative of the general practitioners of the area served by the medical school to its faculty and vice versa.

D. The objectives of appropriate preceptorship training, family clinic training and general practice internships and residencies are recognized as desirable. Some progress has and is being made in these directions but the programs are as yet incomplete.

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REPORT FROM AMA INSTITUTE—"MEDICINE IN ACTION"

A stimulating and self-questioning program, a keenly alert audience—these were the ingredients of the annual AMA public relations institute in Chicago, August 31 and September 1.

Leaders from the fields of medicine, religion, education, communications and government directed the program into channels of thoughtful study and self-analysis.

Under discussion was American Medicine in Action—the image it creates and the relationship of the American Medical Association to the individual physician.

Key problems were faced squarely and probable solutions were evaluated. Along with this "airing of problems" came the strong realization that there is much work to do, and that this work can be most successfully achieved through organization.

AMA offers the core of organization. It offers the tools. In turn it needs every thoughtful, dedicated physician in the United States to put these tools to good use.

Over and over again it was emphasized that much of AMA's work must be accomplished by members at the county and state levels. These workers will find that the strength of the national organization and its amazingly comprehensive facilities are readily available to them.

To back up its 10-point 1961 program AMA offers booklets, speeches, exhibits, films, newsletters, slide films, packets, individual reference services, manuals, radio scripts and television presentations.

The program, with its supplementary aids, is clearly indicative of AMA's desire to serve both the public and the profession by solving current medical and health problems.

Under study are the following vital areas:

1. Costs of medical care.
2. Voluntary health insurance.
3. Help to the needy and near-needy.
4. Health of the aged.
5. Mental Health, including the sponsorship of the first National Congress on Mental Health.
6. Physician supply—student honors and loan program coupled with continuing doctor-recruitment efforts, expansion of medical schools, creation of new ones.
7. Research—encouragement of basic and long range research in medical sciences.
8. International Health — new programs involving missionary cooperation and other agencies to help improve the health of all peoples.
9. Preservation of freedom of patients and physician.
10. Health and safety education.

A tremendous amount of work is being done in all of these areas at the national level. And yet the final success of this program rests on the action that is taken at the state and county society levels. AMA has provided the leadership and the support. It would be difficult to find another profession whose national organization offers so much tangible help. But, in the final analysis, the public image created by the American Medical Profession will depend on the individual physician and his diligence in fulfilling his obligation as a member of AMA.

If anyone should doubt the importance of this work he has only to review the fallacies which are often spread about AMA. These fallacies appear in newspapers, on radio and television. They are written or spoken because of misunderstanding, misinformation or lack of knowledge. Such fallacies can cause "brush fires" in varying degrees of destructiveness. Such a fire may break out anywhere, at any time. The national organization cannot be on the scene to quell each fire. This work rightfully belongs in the hands of the state and county societies. For this reason it is valuable to recognize the most persistent fallacies about AMA.

1. The AMA opposed Blue Cross when it was first proposed.
2. The AMA opposed the Social Security Act in 1935 when it was adopted.
3. The AMA is always "against" everything and never "for" anything.
4. The AMA exercises strong sanctions against individual doctors who speak up against AMA policy.
5. The AMA is a closed corporation (or conversely, a strong union) to which every physician is forced to belong and which controls the supply of doctors in this country.
6. The AMA is ruled by a small clique of doctors.
7. The AMA is against old people and the poor.
8. The AMA should not be mixed up in politics.
9. Doctors oppose the social security approach to medical care only because it would hurt their pocketbooks.

The facts to refute these fallacies are self-evident. Additional facts are readily available on request from AMA. Each physician in the United States strengthens his own position when he takes the time to refute them. It is a vital task in the creation of true and favorable public relations, or public imagery, which is the life blood of any profession or industry in our complex age. When the individual physician fails to take an active part in AMA work he is acting against himself and his fellow practitioners.

While American medicine faces many problems, the climate of the two-day clinic was optimistic. But it was emphasized over and over again that such optimism is warranted *only* if all AMA members work together. The importance of encouraging non-member physicians to join AMA was underscored. Their reluctance, for whatever reason, should be countered by invitation and by education.

Representatives of other professions who addressed AMA delegates spoke frankly of their impressions of the medical world. On the whole they are "friends in court," valuable friends who will support American medicine at local, state and national levels.

At the same time, their laymen's perspective focuses on areas where hard work is needed if American medicine is to continue to flourish in the healthy climate of freedom, a freedom which has brought this nation the finest medical and health care standards in the world.

One individually poor image can do sufficient harm to require the work of an entire state society to repair the damage done to its corporate image. Thus each physician should be vitally concerned with his profession's public relations. He is, within his community, the image of American medicine.

Physicians who attended the two-day seminar, went away impressed with this fundamental truth. At the final afternoon session informal round-table forums discussed many phases of AMA's work. The faces around these tables mirrored the earnest and enthusiastic desire of the individuals to carry on this work at state and county levels.

The AMA offers strength, sound organization and invaluable aids to its physician members. But these are dormant qualities until they are translated into "Medicine in Action" by the individuals who form the body of the American medical profession.

J. M.

Announcements

CIRCUIT COURSES

YOU are cordially invited to attend
one of the 1961-62 Circuit Courses of the Department of Postgraduate Education of the Medical College of South Carolina.

A Symposium On
RECENT ADVANCES IN CORONARY DISEASE
Under the auspices of the South Carolina Academy of General Practice.

Spartanburg, South Carolina — Country Club
Tuesday, October 24, 1961 — 5:30 - 10:00 P. M.

SCHEDULE:
Symposium begins at 5:30 P. M.
Refreshments and dinner 7:30 (Dutch)
Discussion 8:30 to 10:00 P. M.

FACULTY:
Dr. Dale Groom, Asst. Professor of Medicine
Dr. E. E. McKee, Assoc. Professor of Pathology
Dr. J. M. Stallworth, Assistant Professor of Surgery
Dr. Edwin Boyle, Associate in Medicine

Guest Speaker:
Dr. Ernest Craig, Associate Professor of Medicine, University of North Carolina School of Medicine
Approved for 4 hours credit, Category I, by the Academy of General Practice.
R.S.V.P.—Dr. George W. Price, Jr.
120 Hall St.
Spartanburg, S. C.

A Symposium On
THYROID DISEASES—DIAGNOSIS & TREATMENT
Under the auspices of the South Carolina Academy of General Practice and the York County Medical Society.

Rock Hill, South Carolina — Elks Club, Main Street
October 25, 1961 — 5:30 to 10:00 P. M.

SCHEDULE:
Symposium begins at 5:30 P. M.
Refreshments and dinner 7:00 to 8:00 P. M.
Discussion 8:00 to 10:00 P. M.

FACULTY:
Dr. John Buse, Assistant Professor of Medicine
Dr. Maria Buse, Instructor in Chemistry
Dr. R. R. Bradham, Acting Chairman, Dept. of Surgery

Guest speaker:
Dr. Wayne V. Greenburg, Assistant Professor of Medicine, Medical College of Georgia
Approved for 3½ hours credit, Category I, by the Academy of General Practice.
This presentation is supported by a grant from Eli Lilly Company for postgraduate medical education.
R.S.V.P.—Dr. Frank Kiser
1251 W. Oakland Avenue
Rock Hill, South Carolina

AMERICAN CANCER SOCIETY'S SCIENTIFIC SESSION PROGRAM

Biltmore Hotel, N. Y. — October 23-24, 1961

The Physician and the Total Care of The Cancer Patient.

Inquiries concerning this program should be addressed to Director, Professional Education, American Cancer Society, Inc., 521 West 57th Street, New York 19, N. Y.

The State Board of Medical Examiners of South Carolina now has an official directory containing the Medical Practice Laws of the State of South Carolina and a list of all the licensed physicians within the state. The list gives the physician's license number, name, type of practice, and the address. This information is printed as it appears in the records of this Board. The Board feels this is a necessary service; your support will be appreciated. The directory is available at $2.00 per copy. Please make remittance to:

STATE BOARD OF MEDICAL EXAMINERS
OF SOUTH CAROLINA
N. B. HEYWARD, EXECUTIVE SECRETARY
1329 BLANDING STREET
COLUMBIA, SOUTH CAROLINA

FOUNDERS' DAY 1961

This annual occasion is one of importance professionally and socially to the alumni of the Medical College of South Carolina and, we hope, to all the doctors in the State.

The scientific programs arranged for this year will feature speakers on a wide variety of subjects. Every person attending is sure to find something that will be of benefit to him in his practice—cancer, heart, abnormal pregnancies and conception control, hypertension, crash protection of air transport and automotive vehicle occupants, asthma and emphysema, diabetes, are some of the fields of interest on the program.

The Alumni Luncheon and the evening reception and banquet make this occasion in the year a festive one always enjoyed by those who attend. Make a note on your calendar now — FOUNDERS' DAY is NOVEMBER 2, 1961.

S. C. CHAPTER OF THE AMERICAN COLLEGE OF SURGEONS

The South Carolina Chapter of the American College of Surgeons will hold its annual meeting in the Amphitheater of the Medical College Hospital on Wednesday, November 1, 1961, at 4 P. M. Dr. John Steinhaus, Professor and Chairman of the Department of Anesthesiology at Emory University, will talk on "General anesthesia as a cause of cardiac arrest" and Dr. Michael DeBakey, Chairman and Professor of Department of Surgery at Baylor University, will talk on "Renal revascularization". The surgical resident who wins the contest sponsored by the Chapter will read his paper at this meeting.

FOUNDERS' DAY PROGRAM

November 2-3, 1961

THURSDAY, NOVEMBER 2nd

MORNING SESSION

Presiding, Dr. Henry F. Ross, President, Alumni Association of the Medical College of South Carolina

8:30-9:00—REGISTRATION
Greetings—Dr. John T. Cuttino
9:15—Traumatic Maxillofacial Injuries
Dr. Robert F. Hagerty
9:30—Systemic Effects of Local Anesthetics—Toxic or Therapeutic
Dr. John E. Steinhaus
10:00—Management of Abnormal Uterine Bleeding With New Progestational Steroids
Dr. Robert W. Kistner
10:30—Question Period
10:45—COFFEE BREAK
11:00—Our Knowledge of the Pituitary as of 1961
Dr. Edward H. Rynearson
11:30—Surgical Treatment of Occlusive Disease of the Carotid and Vertebral Arteries
Dr. Michael E. DeBakey
12:00—Question Period
12:30—ALUMNI LUNCHEON—Alumni Memorial House

AFTERNOON SESSION

2:00—Assembly in Baruch Auditorium for Assignments (all in Medical College Hospital)
Schedule:
2:30—Clinical Conference #1—Nurses Classroom, 2nd floor
Subject: The Difficult Diabetic—Dr. John Buse
2:30—Clinical Conference #2—Hospital Amphitheater
Subject: Circulatory Insufficiency of the Lower Extremities—Dr. J. Manley Stallworth
2:30—Clinical Conference #3—Board Room, 2nd floor
Subject: Management of Asthma and Emphysema—Dr. Kelly T. McKee
2:30—Medical Ward Rounds—6th floor
Surgical Ward Rounds—5th floor
3:30—COFFEE BREAK—Cafeteria—2nd floor
4:00—Clinical Conference #1-B—Nurses Classroom, 2nd floor
Subject: The Difficult Diabetic—Dr. John Buse
4:00—Clinical Conference #2-B—Hospital Amphitheater
Subject: Circulatory Insufficiency of the Lower Extremities—Dr. J. Manley Stallworth
4:00—Clinical Conference #3-B—Board Room, 2nd floor
Subject: Management of Asthma and Emphysema—Dr. Kelly T. McKee
4:00—Pediatric Ward Rounds—9th floor Classroom
Obstetrical and Gynecological Ward Rounds—8th floor Classroom

EVENING

7:00—ANNUAL RECEPTION and BANQUET, Alumni Association and Guests.
Francis Marion Hotel (Park in adjacent Sears parking lot)
Refreshments
Dinner, Presiding, Dr. John T. Cuttino, Acting President, Medical College of South Carolina
Vignette of a Founder—James Edwards Holbrook—Dr. J. I. Waring
The Challenge of Manned Space Flight—Colonel John Stapp, M. C., U. S. Air Force

The Orthopedic Staff puts on a fracture Clinic with demonstration of newer methods of treatment. Drs. Siegling and Belser (in background) answer questions.

Demonstrations of Cancer Clinic instruments and techniques for office diagnosis of cancer. Dr. John Hawk wields the proctoscope.

FRIDAY, NOVEMBER 3rd

MORNING SESSION

Presiding—Dr. Swift C. Black, President, South Carolina Chapter of American Academy of General Practice

9:00—Acyanotic Congenital Heart Disease—Roentgenologic Aspects
Dr. John J. Kane

9:30—The Twentieth Century's Best Diagnostic Tool in Cancer—Cytology
Dr. Robert J. Samp

10:00—True Hyperinsulinism vs. Functional Hypoglycemia
Dr. Edward H. Rynearson

10:30—Question Period

10:45—COFFEE BREAK

11:00—Diagnosis and Treatment of Depressive Reactions
Dr. William C. Miller, Jr.

11:15—Crash Protection of Air Transport and Automotive Vehicle Occupants
Colonel John P. Stapp

11:45—CLINICAL PATHOLOGICAL CONFERENCE
Guest clinician—Dr. Wilson Greene
Pathologist—Dr. H. Rawling Pratt-Thomas

12:45—LUNCH

AFTERNOON SESSION

Presiding—Dr. William M. McCord, President, Charleston County Medical Society

2:00—Cyanotic Congenital Heart Disease—Roentgenologic Aspects
Dr. John J. Kane

2:30—Newer Concepts of the Pathogenesis of Hypertension
Dr. Cheves McC. Smythe

2:45—Use of the Newer Progestins in Abnormal Pregnancy States and Conception Control
Dr. Robert K. Kistner

3:15—Question Period

3:30—COFFEE BREAK

3:45—Fat Embolism—Experimental Course and Treatment
Dr. Frederick E. Kredel

4:00—Panel Discussion on Nephritis
Dr. Cheves McC. Smythe, Moderator
Dr. Forde McIver
Dr. John R. Paul, Jr.
Dr. A. V. Williams

The Dermatology Staff (here Dr. Kathleen Riley) presents patients with interesting dermatological problems — their histories, pathology, diagnosis and treatment.

SURGICAL COURSE AT EMORY

The Department of Surgery of Emory University is planning a Postgraduate Course in Cancer Chemotherapy, to be presented by authorities at Emory University Hospital, October 19 and 20, 1961.

In addition to the faculty members of Emory University, the following guests will participate:

Dr. Warren H. Cole
Professor of Surgery
University of Illinois
Chicago, Illinois

Dr. Robert K. Ausman
Associate Director
Roswell Park Memorial Institute
Buffalo, New York

Dr. Robert Sullivan
Director of Cancer Chemotherapy
Lahey Clinic
Boston, Massachusetts

Dr. Julius Wolf
Chief of Medicine
Bronx Veterans Administration Hospital
Bronx, New York

Those who are interested can request information from Dr. J. D. Martin at Box 459, Emory University, Atlanta 22, Georgia.

AMERICAN HEART ASSOCIATION'S 1961 SCIENTIFIC SESSIONS TO INCLUDE 6 PROGRAMS ON CLINICAL CARDIOLOGY

Six sessions on clinical cardiology will be included in the 34th annual Scientific Sessions of the American Heart Association, to be held October 20-22 at the Americana Hotel, Bal Harbour, Miami Beach, Florida. A panel or symposium including related investigative work will be presented at each clinical session.

In addition, a total of 18 other scientific sessions will be held concurrently during the three day program.

As in previous years, scientific and industrial exhibits will be on display.

Registration forms, which include applications for hotel reservations, may be obtained from the American Heart Association, 44 East 23rd Street, New York 10, N. Y.

CHARLOTTE POSTGRADUATE SEMINAR
OCTOBER 18, 19, 1961
PRESBYTERIAN HOSPITAL SCHOOL OF NURSING AUDITORIUM

c/o John Harloe, M. D., Chairman
Suite 305, Hawthorne Medical Center
Charlotte 4, North Carolina

A Series of Lectures in
OPHTHALMOLOGY

will be held in the Eye Clinic, Duke Hospital on September 9, October 20, 21, November 3, 4, 10, 11, 1961 and February 10, May 3, 4, 5, 1962.

All interested physicians are invited. For further information write J. Lawton Smith, M. D., assistant professor of Ophthalmology, Duke University Medical School.

CONFERENCE ON DISASTER MEDICAL CARE TO BE HELD IN CHICAGO

The 12th County Medical Societies AMA Conference on Disaster Medical Care will be held in Chicago, November 4-5, at the Palmer House.

"A How Do You Do It at the County Level" is the basic theme of the national meeting which is sponsored by the American Medical Association's Council on National Security.

Information regarding the conference can be obtained by writing Mr. Frank W. Barton, Secretary, Council on National Security, American Medical Association, 535 N. Dearborn, Chicago 10, Illinois.

AMERICAN ASSOCIATION OF INHALATION THERAPISTS

The above mentioned association will hold its seventh annual meeting and lecture series at the Statler-Hilton Hotel, Buffalo, New York, November 6-9, 1961. To register write Mr. Albert Carriere, Executive Director of the Association, 332 South Michigan Avenue, Chicago 4, Illinois.

UNC SCHOOL OF MEDICINE FIFTH ANNUAL SYMPOSIUM

NOVEMBER 9 - 10, 1961, CHAPEL HILL
Postgraduate Course in Infectious Diseases With Emphasis on Methods of Diagnosis, Treatment and Prevention of the Common Infections

Staffed by the Divisions of Infectious Disease of the Departments of Medicine and Pediatrics of the UNC School of Medicine, with Dr. L. W. Wannamaker, University of Minnesota School of Medicine, as Guest Participant.

A Syllabus of Cases to be Discussed will be mailed to All Registrants in Advance.

EMORY OPHTHALMOLOGICAL MEETING

The annual postgraduate meeting sponsored by the Department of Ophthalmology, Emory University School of Medicine will be held on Thursday, November 30 and Friday, December 1, 1961, at the Grady Memorial Hospital Auditorium, Atlanta.

Diagnostic methods of examination of the ocular fundus, clinical manifestations, differential diagnosis and pathologic anatomy of lesions of the vitreous, uvea, retina and optic nerve will be presented.

The guest lecturers will be Dr. Algernon B. Reese, Clinical Professor of Ophthalmology, College of Physicians and Surgeons, Columbia University, New York, N. Y.; Dr. Charles L. Schepens, Clinical Associate in Ophthalmology, Harvard Medical School, Boston, Mass.; and Dr. Lorenz Zimmerman, Chief, Ophthalmic Pathology Branch, and Registrar, Registry of Ophthalmic Pathology, Armed Forces Institute of Pathology, Washington, D. C.

For further information write the Director, Postgraduate Education, Department of Ophthalmology, Emory University School of Medicine, 80 Butler St., S. E. Atlanta 3, Georgia.

Deaths

DR. HERBERT E. VAUGHAN

Dr. Herbert E. Vaughan, retired physician, died in a Columbia hospital after an illness of three months. He was a native of Timmonsville and had practiced medicine in Fountain Inn for the past 20 years.

Before coming to Fountain Inn, Dr. Vaughan had practiced at Reidsville in Spartanburg County. He was a graduate of the University of South Carolina and the South Carolina Medical College at Charleston in the class of 1911.

DR. JOSIAH E. SMITH

Dr. Josiah E. Smith, eye, ear, nose and throat specialist in Charleston since 1920, died September 14 at his residence, 78 East Bay St. His age was 71.

A native of Charleston, Dr. Smith was born November 2, 1889. He attended the College of Charleston and the Medical College of South Carolina, receiving the degree of bachelor in pharmacy.

At the Jefferson Medical College in Philadelphia, he received his degree as doctor of medicine in 1916. He served on the staff of the Medical College and at Roper Hospital for a number of years.

In 1936, Dr. Smith was elected alderman, and represented Ward 6 on City Council. He was chairman of the Charleston Housing Authority from 1936 to 1960, when he resigned.

In the past, Dr. Smith had also been a commissioner for the Charleston Orphan House, the Charleston Free Library, and the Charleston Housing Commission.

He was a member of St. Philip's Protestant Episcopal Church, Kappa Alpha literary fraternity, Phi Alpha Sigma medical fraternity, Alpha Omega Alpha honorary medical fraternity; past master of Landmark Lodge No. 76, AFM; and he was a 32nd degree Mason of Scottish Rite.

He was also a member of the Medical Society of South Carolina, the South Carolina Society, the St. Andrew's Society, the American Medical Association, the Southern Medical Association, the Southeastern Surgical Society and was a fellow in the American College of Surgeons.

DR. S. C. LIND

Dr. S. C. Lind, 75, retired surgeon died August 15.

Dr. Lind was born in Canton, Ohio, but lived most of his life in Cleveland, Ohio. He received his medical degree from Western Reserve University and finished cum laude.

He was president of Academy of Medicine of Cleveland, American College of Surgeons and the Cleveland Surgical Society. A veteran of World War II, he served as chief of surgery in the Naval Hospital, San Diego, Calif., also shief of surgery in major battles of the Pacific. He was also head of the surgical staff of Lutheran Hospital, Lake Wood Hospital and Deaconess Hospital, all of Cleveland.

He retired seven years ago, moved to Myrtle Beach and has been active in local medical activities since moving here. He was recently presented a distinguished service award from the medical staff of Ocean View Memorial Hospital.

DR. E. C. HOOD

Dr. Eugene C. Hood, 65, of Florence, retired superintendent and medical director of the Florence-Darlington Tuberculosis Sanatorium, died August 19 after an illness of six months.

Dr. Hood was born March 9, 1896, in Hood Town Community in York County. He was superintendent and medical director of the sanatorium for 31 years until his retirement in 1960.

During World War I, he served in France with the United States Army.

He was a member of Central Methodist Church, Fred H. Sexton Post No. 1, American Legion, a charter member of the American College of Chest Physicians, Theta Kappa Psi medical fraternity and the American Trudeau Society.

Dr. Hood was a graduate of Wofford College, the College of Charleston, the Medical College of South Carolina (1930), with a degree in medicine and pharmacy, and attended the University of Touleges in France. He taught bacteriology and pharmacology at the Medical College.

News

RESOLUTIONS ADOPTED BY THE COLUMBIA MEDICAL SOCIETY ON THE DEATH OF DR. W. A. BOYD

WILLIAM AUGUSTUS BOYD, M. D. 1881 - 1961

Whereas on early Wednesday morning, June 28, 1961, in Columbia Hospital, there passed to higher spheres of usefulness a gentleman, the pioneer of orthopaedic surgery in South Carolina.

There are few men of whom another can say "I love him", but Doctor Billy was such a one. Surely he was the best loved orthopaedic surgeon in his chosen specialty.

William Augustus Boyd, M. D., was born in Charleston, South Carolina, March 19, 1881, into a distinguished family, the son of the late Bernard and Joana W. Sherfesee Boyd. He was graduated from Charleston High School, attended the College of Charleston, and was graduated from the Philadelphia School of Anatomy, and the University of Pennsylvania Medical School.

After receiving his medical degree from the University of Pennsylvania in June, 1903, he served an internship in Howard Hospital, Philadelphia, and was chief resident at the Philadelphia Orthopaedic Hospital.

Dr. Boyd began private practice in Columbia, South Carolina, in September, 1904. He served as city health officer 1910-1915.

On February 14, 1906, he was married to Miss Mary Sweat Keller of Meinhard, Georgia, who survives him. Out of this union, there was one daughter, Miss May Keller Boyd, who also survives him.

Dr. Boyd was Vice-President of the South Carolina Medical Association; President of the Columbia Medical Society; Orthopaedist to the Advisory Board, Selective Service; Orthopaedist to State Board of Health; Chairman, Advisory Board, State Board of Health; and Counselor, American International Society of Medicine.

Dr. Boyd was a member of the active staff of the Columbia, Baptist and Providence Hospitals, and consultant orthopaedist of Saunders Memorial Hospital, Florence, South Carolina.

Dr. Boyd has recently received a letter from Belgium recognizing him in the field of Crippled Children, and informing him that he had been elected a Fellow of the International Society of Surgery.

Although a young physician of the days when the general surgeon ruled supreme, he was a firm believer in specialization. Those who were privileged to serve him came under his spell at once, and when their preceptorship was over, they found that they had gained much knowledge and a lifelong friend. Age was a factor he scarcely recognized, except that he sought the company of the young rather than the old. He talked to the young surgeon like a colleague. He was so capable of discussing surgical problems that almost as much surgery could be learned while talking with him as while watching him at work.

As a raconteur he was unsurpassed. At almost every gathering, he was called on to tell one of his famous stories, many of which were developed from his own experiences. He was master of many dialects and pantomime, and thrilled his audiences. As a host, he was most delightful. His chesterfieldian manner exhibited the charm of the old South.

Dr. Boyd's vision, ambition, knowledge, and surgical skill led him to greater attainments. He organized the Crippled Children's Clinic at Columbia Hospital in 1920. He had to appeal annually to the legislature for funds to carry on this Clinic. This work expanded and his interest increased with advancing years. This Clinic remained dear to his heart and he personally conducted it until the time of his death.

He was a member of the Columbia Medical Society, the South Carolina Medical Association, the South Carolina Orthopaedic Association, the North Carolina Orthopaedic Association, a member of the Georgia Orthopaedic Association, the Southern Surgical Association, Southeastern Surgical Congress, American Orthopaedic Association, American Academy of Orthopaedic Surgeons, American Medical Association, National Rehabilitation Association, American Association of Railway Surgeons, Southern Railway Surgeons, Association of Seaboard Air Line Railway Surgeons, Association of Atlantic Coast Line Surgeons. He had the distinction of being the only person ever to serve as president of all three of these railway associations. He was a Fellow of the American College of Surgeons. In 1960, he was elected president emeritus of the South Carolina Orthopaedic Association.

He was an honorary member of Blue Key, University of South Carolina Chapter. He received a citation for his contribution to selective service system by the President of the United States, Governor of the State of South Carolina, and the Senator from the State of South Carolina.

Dr. Boyd was a member of Trinity Episcopal Church, Columbia, South Carolina, a member of Kiwanis Club, Forest Lake Country Club, Pine Tree Hunt Club, South Caroliniana Society, Kappa Sigma Fraternity, Executives Club, and Columbia Cotillion.

Dr. Boyd was the author of many scientific papers which were published in various medical journals. In these publications he defended, defined, enlarged and modified with his own observations and experiences, the newer trends in orthopaedic surgery.

Dr. Billy, as he was affectionately known to his legion of friends, was distinguished not only in his profession, but his charm as a physician endeared him to everyone who had the good fortune to know him.

He lived for his patients and for his surgery. His patients adored him. The red rose worn daily in his lapel was furnished by a friend whom he helped in time of great distress.

A group of his friends, both within and outside the medical profession, arranged for a portrait of Dr. Billy which was presented to the Columbia Hospital and now hangs in the lobby of that institution. At ceremonies attending the unveiling of the portrait, tributes were paid which attested the love people in every walk of life had for him.

THEREFORE, BE IT RESOLVED BY THE COLUMBIA MEDICAL SOCIETY:

That the Society has lost a valued, distinguished and esteemed member, and that an era of medicine in this great City has been closed.

That copies of these resolutions be spread on the minutes of this Society and published in the RECORDER, and that a copy be sent to the family of Dr. Boyd with the expressed sympathy and regard of the Society.

Respectfully,
Charles H. Epting, M. D.
Theodore J. Hopkins, M. D.
James T. Green, M. D.

COLUMBIA MEDICAL SOCIETY

The medical staff of the South Carolina State Hospital was host to the Columbia Medical Society for its scientific meeting on August 14, 1961. Dinner was served in the Benet Auditorium prior to the scientific program, where the tables were beautifully decorated by the Cherokee Rose Garden Club.

Dr. Weston C. Cook, President, opened the meeting, and extended a hearty welcome to all visitors in attendance. He expressed thanks on behalf of the members of the Society to the staff of the State Hospital for the pleasure of meeting with them for the August meeting.

Dr. Cook then turned the meeting over to Dr. William S. Hall, superintendent of the South Carolina State Hospital. Dr. Hall welcomed members of the Columbia Medical Society and guests, and then presented a brief progress report on the hospital's activities. It is anticipated that an approved residency training program in psychiatry will be realized in the not too distant future, Dr. Hall said, at the latest date, July 1, 1962.

Plans are presently being drawn up for a 200 bed receiving building, Dr. Hall informed the group. This building will be located immediately east of the the James F. Byrnes Clinical Center, and will include the physical facilities for the residency training program and other instructional programs.

With regard to funds available for patient care, Dr. Hall stated that the overall expenditure per patient per day at the South Carolina State Hospital is $2.96, and that only the state of Mississippi spends less money per patient per day than our State. In 1960, 3,075 patients were admitted, he said, adding that a great number of professionals (which includes doctors, nurses, aides, etc.) are required to provide the best possible care for the mentally ill in our state.

Dr. Hall then introduced the guest speaker, Dr. Robert H. Dovenmuehle, Research Co-ordinator, Duke University Center for the Study of Aging, and Assistant Professor of Psychiatry. Speaking on the subject "Health and Aging", Dr. Dovenmuehle emphasized that physical and mental difficulties, especially in the older age group, are closely interwoven. Patients in this age group tend to look upon physical difficulties as something they will have to live *with*, rather than something they will have to live *through*, he said, contrasting this reaction to that of younger patients who look forward to returning to their normal state of health. Helping these patients to learn to deal with their own reactions to their physical problems is an important factor for the doctor to consider in treating patients in the older age group, Dr. Dovenmuehle said.

COLUMBIA MEDICAL SOCIETY

The November Scientific Meeting of the Columbia Medical Society will be held at the Columbia Hotel, Monday, November 13, 1961, at 7:00 P. M. The guest speaker will be Dr. Paul R. Lipscomb, Rochester, Minnesota, who will address the group on the subject "Prevention and Correction of Deformities of Arthritis". A graduate of the Medical College of South Carolina, Dr. Lipscomb is certified by the American Board of Orthopedic Surgery. He is a member of the American Orthopedic Association, Clinical Orthopedic Society, American Academy of Orthopedic Surgeons, American Society for Surgery of the Hand, and the American College of Surgeons.

The local speaker will be Dr. Hubert Claytor of Columbia, who will speak on "Some Unusual and Serious Problems in Severe Trichinosis".

All interested physicians are cordially invited to attend.

DR. MAULDIN BEGINS PRACTICE IN PICKENS

Dr. David W. Mauldin is now associated with Dr. John M. Harden in the practice of medicine.

Dr. Mauldin is a native of Pickens, a graduate of Pickens High School, the University of South Carolina, of the Medical College of South Carolina, and served his internship at Walter Reed Hospital, Washington, D. C.

The new Pickens physician has had several years experience in medicine, having served a tour in the medical corps of the U. S. Air Force, with duty in Europe. In addition as serving as physician to Air Force personnel, he was also responsible for the health of their wives and children.

DR. COOK NAMED TO POST WITH CRIPPLED CHILDREN

Dr. Weston C. Cook was appointed to succeed Dr. W. A. Boyd as orthopedic surgeon for District III of

the Crippled Children Division of the State Board of Health at the meeting of the Executive Committee on July 19.

District III is composed of Sumter, Newberry, Saluda, Lexington, Edgefield, and Aiken Counties.

Dr. Cook, a native of Pennsylvania, graduated from Lehigh University in 1936 and the University of Pennsylvania Medical School in 1940. He entered the Medical Corps of the Navy in 1940 and came to Columbia in 1943 where he practiced with Dr. A. T. Moore until 1950, after which he opened his own office.

Dr. Cook is certified as an orthopedist by the American Board of Orthopedic Surgery, is a member of the American Academy of Orthopedic Surgery and the American College of Surgeons. He is on the staff of the Columbia, Providence and Baptist Hospitals in Columbia and is chief of the orthopedic section of the Baptist Hospital. He is also orthopedic consultant to the U. S. Army at the Station Hospital at Fort Jackson and is president of the Columbia Medical Society this year.

CAMERON GETS MEDICAL DOCTOR TO FILL NEED

An essential need for the town of Cameron was filled recently when Dr. B. M. Lawton, Jr., a native of Estill, opened offices for the practice of medicine.

Cameron had been without a practicing physician since Dr. E. M. Borgstedt left some time ago to become associated with the State Hospital in Columbia.

After serving in the U. S. Navy Medical Corps from 1950 to 1954, Dr. Lawton attended the University of South Carolina and, in 1956, entered the Medical College of South Carolina, completing the course in 1960. He served his internship at the Medical College Hospital in Charleston.

SEVENTH DISTRICT MEDICAL ASSOCIATION

A meeting of the Seventh District Medical Association was held at Litchfield Beach Club, Georgetown, on September 21, 1961. The speakers were Drs. Peter C. Gazes, Harry W. Mims and Forde A. McIver, all of the Medical College of South Carolina. Current officers for 1960-61 were president, Dr. John Assey, Georgetown; secretary-treasurer, Dr. T. M. Davis, Manning; vice-presidents, Dr. A. C. Bozard, Bob Jones, Sedgwick Simons, John M. Rhame and Keith Sanders.

DR. CARROLL A. PINNER

The CARROLL A. PINNER bridge over the Broad River was officially opened on August 23, 1961, and dedicated to Dr. Carroll A. Pinner of Peak, South Carolina, who has served the communities on both sides of the river by walking the railroad trestle. The new bridge connects Newberry and Fairfield Counties and in particular the towns of Peak and Parr. It is the restoration of an old colonial highway from North Carolina through Camden to Ninety-Six and satisfies local demands for it of long standing. The bridge has two spans, meeting on mile-long Hampton Island, one being 608 feet, the other 912 feet, and its total cost was $414,080. Dr. James C. Kinard, former president of Newberry College, speaking at the dedication ceremonies, called the bridge the answer to Dr. Pinner's prayers, saying, "Only God knows how many times he risked his own life on that trestle in order to save others . . . but no patient ever heard him complain of how hard it was to get to his bedside. He always walked in as cheerfully as though he had just come across the street."

DR. HENRY J. STUCKEY

Dr. Henry Jefferson Stuckey, a native of Bishopville, completed a half century of medical service to his adopted community of Bamberg on June 30. Dr. Stuckey remembers the "good old days" of a one teacher school (and his first teacher is still living, Miss Mattie McCutcheon, now Mrs. Laddie Montgomery of Bishopville); a male academy, Catawba at Rock Hill; and the use of a horse, a horse and buggy, or a bicycle as he called on his patients. Dr. Stuckey took his pre-med training at Davidson College and was graduated in medicine from the Medical College of South Carolina in 1910. He has enjoyed a full life as a general practitioner, saying "I consider that I have done more for humanity as a general physician, and have come in contact with more people. If I had to live over again, I would still be a general doctor."

Dr. Blanchard C. Phillips, Jr., upon his release from the Air Force entered upon the practice of general medicine in Williams in July. Dr. Phillips took his undergraduate training at Wake Forest and was graduated from Bowman Gray Medical School in 1957.

Samuel J. Segal, M. D., upon the completion of his Army service, has gone into general practice at Largo, Florida, where his address is 6916 One hundred fourteenth Street, north.

After completion of three years in the Navy where he practiced occupational medicine Dr. Joe S. Matthews, III is now associated in the practice of general medicine with Dr. John Wilson in Darlington.

REWARDING SEASON FOR ORTHOPEDIC CAMPS

The South Carolina Orthopedic Camps, conducted by the State Board of Health, enjoyed a very rewarding seventeenth season, winding up with banquets on July 24 for the 98 physically handicapped children from the central and coastal areas.

Children eligible are those who cannot attend regu-

lar camps or who need the specialized environment for social adjustment. In many cases the young child "graduates" to regular camp after having the modified camp experience for one summer.

Camp offers an ideal opportunity for improving the child's skill in the activities of daily living. In the water, adaptations of standard American Red Cross strokes increase skills and provide needed exercise.

Two counselors work with each group of eight children and guide them in personal hygiene, self-care, and eating habits.

Staffs for both camps are carefully selected to supply mature understanding for the child in the small group.

Dr. Norman S. Richardson, a native of Darlington, is engaged in a partnership practice of medicine in McCormick with Dr. C. H. Strom. Dr. Richardson graduated from the Medical College of South Carolina, Charleston, in 1957, interned at Columbia Hospital, and has been in Germany with the U. S. Army Medical Corps.

Dr. Walter J. McMath, local medical physician who came to Hartsville to practice in the summer of 1956, has moved to his modern office building on Sumter Avenue.

Dr. McMath is a graduate of Howard University medical college and did resident practice at a North Carolina hospital before coming to Bennettsville.

After the completion of a three-year residence in internal medicine at the South Carolina Medical College Dr. William M. Nelson, formerly of Williams, has returned to Walterboro, where he has opened an office in the EsDorn—Stokes Memorial Clinic Building.

Dr. Nelson will specialize in internal medicine.

Dr. Vernon Barry Moore, Greenwood physician, gave the address at Lander College summer school graduation exercises Sunday, August 20.

Dr. Moore's subject was "What's the Hurry"? He is chief of Obstetrics and Gynecology at Self Memorial Hospital and is a native of Brownsville, Tenn.

Dr. Moore came to Greenwood in 1950. He is a diplomat of the American Board of Obstetrics and Gynecology, a fellow of the American College of Obstetricians and Gynecologists, and the American College of Surgeons.

TUOMEY X-RAY SCHOOL IS APPROVED

The Tuomey Hospital school of X-Ray Technology in Sumter has again been granted approval by the American Medical Association it was announced by administrator James Case. Due to stricter requirements schools are reinspected every three to five years and are approved after evaluation of this inspection conducted by the AMA and the American College of Radiology.

Tuomey Hospital, having met all of the requirements, has been given approval for a total of six student X-Ray technicians. Two students are accepted each year in July.

Two-Year Course

The course in X-Ray Technique at Tuomey is for a period of two years. Applicants must be graduates of accredited high schools and one year of college is recommended but not required.

Students in X-Ray technique are taught anatomy, physiology, physics, chemistry, positioning and general X-ray techniques. Upon completion of the two year course, students receive a diploma and are eligible to take the National Board Examinations given by the American Registry of X-Ray Technicians. After passing this National Board Examination a graduate technician becomes a "Registered Technician."

Tuomey Hospital is one of the nine schools in South Carolina approved by the AMA for training X-Ray technicians.

CHILDREN'S MEDICAL CENTER

Construction of The Children's Medical Center on the corner of First Street and Carolina Avenue, Hartsville was announced by its owners, Dr. Griggs C. Dickson and Dr. James C. Parke.

The building will be completed in approximately five months. Drs. Dickson and Parke recently opened their practice of pediatrics in temporary offices at 807 Carolina Avenue.

HOSPITAL UNIT AT FT. BRAGG

Columbia's 446th General Hospital Army Reserve unit went to Fort Bragg, N. C. for two weeks of annual active training at Womack Army Hospital.

Personnel of the 446th was given on-the-job training right in the hospital, working side by side with regular Womack personnel.

The 446th personnel includes 10 doctors, eight nurses, and 23 students from the Medical College of South Carolina at Charleston.

The 446th is commanded by Colonel James G. Shaw, a Columbia physician. Colonel Shaw has commanded the unit since it was activated in 1957. He was commissioned in the Medical Corps of the Army Reserve in 1935, and during World War II he saw action in Europe.

COMMUNITY NEEDS DOCTOR

Calhoun Falls, a community of approximately 2,500, needed a doctor badly according to an article in the Anderson Independent in July. Whether this need has by now been met we do not know. The newspaper article stated the town had formerly had two physicians and this was the first time in years it had been without a resident doctor. The nearest communities from which medical attention now has to be obtained are Abbeville, 15 miles away, Elberton, Georgia, 19 miles, McCormick, 25, and Greenwood and Anderson, 32. With an outlying population of more than 6,000 it is believed by the people of Calhoun Falls that their

community could well support one or two practicing physicians.

DR. ERIC MARVIN DIBBLE

Dr. Eric Marvin Dibble, now 83, almost blind and supposedly retired, is still in demand by patients who just refuse to give up his kind and knowledgable services. Dr. Dibble, born in Charleston in 1878, has practiced medicine in Marion since 1903 and is considered one of the institutions of Marion. When the new wing of the Marion Memorial Hospital was opened to the public in July a life-size oil portrait of the physician was hung in its foyer, he having been for many years its chief of staff. Dr. Dibble visits the hospital daily and according to one of his patient's "If Dr. Dibble just comes in the hospital room and looks at us, we know we'll be all right—we have so much faith and confidence in him."

Dr. Dibble did his undergraduate work at the College of Charleston and was graduated from the South Carolina Medical College in 1900. He interned at Roper and began his practice in Greenwood with his uncle, Dr. R. B. Epting, but entered upon his own practice in Marion when an opportunity there presented itself. Except for a year in 1918 when he served in the Army Medical Corps, Dr. Dibble has faithfully served Marion. For ten years he was president of the State Board of Medical Examiners, on which Board he has served from 1924 to 1956; he has been president of the Pee Dee Medical Society and vice-president of the South Carolina Medical Association.

Dr. Joseph Henry Cutchin of Easley is chairman of the Board of Directors of the state chapter of the American Academy of General Practice. Dr. Horace M. Whitworth of Greenville has been appointed to the standing committee of the Academy for the selection of the recipient of its Ross Award.

HOSPITAL ACCREDITATION MEETINGS

The matter of hospital accreditation is of vital interest to all practitioners who make use of the hospitals of the state, and also to those selected physicians or lay people who are members of the boards of these hospitals. Physicians who have not served on hospital boards have relatively little conception of the duties and responsibilities of board members. These two meetings to be held in October are intended to provide a gathering of hospital administrators, hospital board members, and physicians in general. All physicians are invited to attend and to take advantage of this opportunity to hear explanation of the problem of hospital administration from a top authority on the subject, Dr. Kenneth B. Babcock, director of the Joint Commission on Accreditation of Hospitals. All members of the Association are urged to attend.

One of these meetings will be held at the Greenville General Hospital on October 24, 1961, and the other at the Florence Country Club on October 25, 1961. Both meetings are scheduled at 7:00 p. m. and Dr. Babcock will make an address which will be followed by dinner for all present and a question and answer period after dinner.

The subject of the address will be The Program of the Joint Commission on Accreditation of Hospitals.

Dr. M. T. Laffitte, Jr., formerly of Estill, has opened his office for the practice of Obstetrics and Gynecology at 1812 Hampton St. He will be associated with Dr. Heyward H. Fouche.

Dr. Laffitte took his pre-medical education at The Citadel in Charleston. He obtained his M. D. degree from the Medical College of South Carolina in 1955 and completed his internship there the following year.

Upon entering the service in July, 1956, he served in the Army Medical Corp practicing Obstetrics and Gynecology at Fort Jackson, and later at Fort Rucker, Ala.

After discharge from the Army he returned to the Medical College to complete his residency. The past year was spent as a Research Fellow in Obstetrics and Gynecology.

Dr. C. Wallace Harper has opened offices at 7 S. Calhoun St., Greenville, after completing internship and post-graduate training.

A native of Greer, Dr. Harper took his pre-medical education at Wofford College and Duke University, graduated from the Medical College of South Carolina and served his internship at St. Louis City Hospital, St. Louis, Mo.

In post-graduate training he obtained a fellowship in hematology at Emory University School of Medicine, Atlanta, Ga. He is a member of Phi Rho Sigma medical fraternity.

Dr. S. A. Greenberg of 234 S. Dargan St., Florence, announced he will be joined in his practice by Dr. Donald M. Gelb.

Dr. Gelb won a Ford Foundation Scholarship to the University of Chicago 1951 and 1952. He was graduated Phi Beta Kappa from the University of Rochester with a B.A. degree in psychology.

Dr. Gelb was graduated from Chicago Medical School in 1959, where he was a four year member of Phi Lambda Kappa.

Dr. Gelb spent 1959 and 1960 in rotating internship, and his residency was at Mt. Sinai Hospital, Chicago, in 1960 and 1961.

Eugene F. McManus, M. D. announces the opening of his office at Highway 703—At Rifle Range Road, Mt. Pleasant. Practice limited to Pediatrics.

Frank O. Bartel, M. D. announces the opening of his office for the practice of Pediatrics at 141 N. Dean Street, Spartanburg.

Dr. Ambrose G. Hampton, Jr., is back in Columbia after two years in Paris where he has been practicing

internal medicine at the American Hospital.

Dr. Hampton will resume his medical practice in Columbia.

Dr. J. L. Altman, formerly of Charleston, has moved to Andrews and will engage in general practice of medicine.

Dr. Altman is a graduate of the University of South Carolina and the Medical College of South Carolina. After receiving his degree from the Medical College in 1957 he served his internship at the Orangeburg Regional Hospital and practiced for a short time in Charleston. Since 1959 he has served on the staffs of hospitals in Tennessee and Pennsylvania.

CONGENITAL HEART DISEASE PROGRAM

In November 1959 a Congenital Heart Disease Program was established through a cooperative arrangement with the Heart Disease Control Section and the Crippled Children's Division of the State Board of Health. Any child under 21 years of age who is suspected of having a congenital heart condition and whose family is medically indigent is eligible for diagnostic work-up at the Medical College Heart Clinic.

If the diagnosis of congenital heart disease is confirmed, the child is eligible for treatment under the auspices of the Crippled Children's Division, South Carolina State Board of Health. Children considered to be in need of this service may be referred by private physicians, Heart Disease Control Clinics, Rheumatic Fever Clinics, Health Departments, etc.

Application for this service is made through local County Health Departments to the Crippled Children's Division of the State Board of Health.

All children accepted on this program are referred to the Medical College Heart Clinic for special diagnostic procedures, treatment and surgery as indicated. The Medical College Heart Clinic schedules all appointments and works very closely with referring physicians and County Health Departments in treatment planning and follow-up care.

In addition to this service there are five Regional Heart Centers in the United States, sponsored by the U. S. Children's Bureau. Patients with congenital heart conditions may be referred to these Centers if and when it is considered advisable.

Civil Defense

AMA "SUMMARY REPORT" AVAILABLE

The AMA's Department of National Security will continue to fill requests from physicians without charge for quantities up to 25 of the "Summary Report on National Emergency Medical Care". A unit price of $.25 will be charged for larger orders. Orders should be addressed to: Council on National Security, AMA, 535 North Dearborn Street, Chicago 10, Illinois.

MANAGEMENT OF MASS CASUALTIES COURSE

Under the quota allotted to the AMA Council on National Security by the Army Surgeon General, spaces are still open for physicians to attend the above course at Brooke Army Medical Center, Fort Sam Houston, Texas, on the following dates: November 13-17, 1961; February 5-9, 1962; and April 2-6, 1962. Physicians who desire to attend any of these courses are requested to write directly to the Council on National Security. Names and addresses of those desiring to attend must be furnished by the Council to the Army Surgeon General not later than four (4) weeks prior to the scheduled course date.

CIVIL DEFENSE EMERGENCY HOSPITAL PROGRAM

Charleston was the 26th city in South Carolina to be allocated a $100,000 Civil Defense Emergency Hospital.

The Charleston unit is one of three training hospitals used to train medical and allied health personnel in techniques of establishing and operating the emergency medical facility. The other training units are located at Greenville and Columbia.

Charleston has also been selected as a possible site of a prepositioned hospital. Additional prepositioned hospitals are being allocated by DHEW during the present fiscal year. This type of unit is stored for use only in an extreme emergency and is not used or displayed as are the three training units. Prepositioned hospitals are strategically stored throughout the state at the following locations: Anderson, Bennettsville, Bethune, Calhoun Falls, Conway, Darlington, Dillon, Columbia, Florence, Kingstree, Lancaster, Laurens, Moncks Corner, Newberry, Rock Hill, Saluda, Spartanburg, St. George, Sumter, Walhalla, Walterboro, Ware Shoals, Winnsboro.

The 200-bed Civil Defense Emergency Hospital is designed to provide emergency medical care facilities to casualties in time of major natural or man-made disaster. This emergency medical unit would be one of the principal lifesaving tools available to physicians in the event of a major disaster. It is possible that the beds it contains would provide over one-half the usable hospital beds remaining after a mass thermonuclear attack.

This unit is a "packaged" hospital containing all the equipment essential for operating a 200-bed general hospital. Although items such as X-ray units, operating tables, cots and surgical instruments are plain in design, they are comparatively inexpensive, rugged and functional.

Not intended to supplant—but rather to augment—permanent hospitals, the unit is primarily intended to replace hospital facilities destroyed or made unusable in a national emergency.

The emergency unit could be used in any of the following ways:

1. As an auxiliary to an already existing hospital so as to increase the hospital's capabilities quickly under emergency conditions.
2. As a self sufficient facility where no other hospitals are available.
3. As an auxiliary to an already prepositioned civil defense emergency hospital.

The Civil Defense Emergency Hospital is an adaptation of the Surgical Hospital Mobile Army (SHMA) unit developed during the Korean War. Its supplies and equipment have been field tested under severe conditions since they were originally designed for military use. Continuous improvements have been made since 1952, and the hospital has been adapted to civilian rather than military needs.

Major components of the hospital include:

1. Three operating tables, operating lights, surgical instruments needed for basic surgery and anesthesia apparatus.
2. Wards equipped to meet the basic medical needs of 200 bed patients.
3. X-ray equipment complete with its own portable generator and transformer.
4. Pharmacy supplies which include antibiotics, heart and respiratory stimulants and intravenous solutions. (No narcotics are included.)
5. Laboratory supplies which include material to perform tests for blood typing, hemoglobin determination, clotting time, and routine urinalysis. (No microscope is included.)
6. Sterilizing supplies which include nine pressure-cooker type and six boiling type sterilizers.
7. Central Supply provides a re-supply capability in support of all functional departments.
8. A 15-kilowatt generator to provide auxiliary power if local electrical supply is disrupted.
9. A portable 1500-gallon water tank and pumping equipment.

Supplies and equipment (8,000 individual pieces) for the hospitals are maintained through continuous procurement programs and by rotation of certain supplies (drugs) as they become outdated.

No canvas is included as the unit is ordinarily stored and operated in a building such as a school which can be readily converted into an emergency hospital.

The entire hospital weighs 24,000 pounds and is valued at $100,000. An area of 25 x 25 feet is required for storage of the unit. It can be transported in one 40 foot van or several smaller trucks.

Book Reviews

THE CHRISTOPHER HAPPOLDT JOURNAL. Edited with Preface and Biographies by Claude Henry Neiffeur, Associate Professor of English, University of South Carolina. The Charleston Museum, Charleston, 1960. Price $4.00.

In the latter part of 1838 the Rev. John Bachman, eminent divine and naturalist, once of New York, then of Charleston, found that his health required a change of scene. Embarking for England and the Continent, he took with him as a companion and general factotum young Christopher Happoldt, a boy of 14, who was later to develop into an able and outstanding physician in Charleston. The Journal which Happoldt kept on these travels is the basis for this book, although actually the Journal is less important than the biographical accounts of John Bachman and of Christopher Happoldt.

Medical readers will perhaps be more interested in the account of Happoldt's life. After what must have been a very enjoyable experience in the company of Bachman and in the various contacts with scientific people of the day which were made by Bachman and less actively by his protege, Happoldt returned to Charleston and after some years graduated in medicine in 1851 at the Medical College of South Carolina. He then pursued his medical education in Paris and in Berlin, returning to Charleston in 1854, quickly becoming associated with the *Charleston Medical Journal and Review*, one of the early medical journals of the South and one which carried quite an influence in its time. In the next year, Happoldt became the sole editor and assumed all the responsibility for the conduct of the journal. He appears to have been a man of excellent education with a scientific mind and a liking for intellectual society. Unfortunately for this tendency, family matters caused him to leave Charleston in 1858, and remove to Morganton, North Carolina, where he became a village doctor without the opportunities of fulfillment of his earlier promise. However, he still remained the willing volunteer in times of need, becoming a surgeon in the Confederate Army and being held as a prisoner for some time. Later he was to offer himself as a worker in the yellow fever epidemic in Memphis, and again in Vicksburg, where he himself became a victim of the disease.

The life of Bachman is detailed in respect to his literary, religious and scientific activities. Of major interest is his association with John James Audubon, whom he entertained extensively in his home and to whom he rendered great assistance in his ornithological excursions in the neighborhood of Charleston. His collaboration with Audubon in the production of *The Viviparous Quadrupeds of North America* is well known. Bachman girls married Audubon men, and Audubon named a warbler for Bachman as evidence of mutual esteem. Bachman's interests were numerous, his character estimable. The account of his life should be particularly interesting to South Carolinians.

J.I.W.

FUNDAMENTALS OF CLINICAL HEMATOLOGY. By Byrd S. Leavell, M. D. and Oscar A. Thorup, M. D. 503 pages. W. B. Saunders Company. 1960. Price $10.00.

The need for a new text in hematology in view of the number already in existence is open to some question unless it fills a specific purpose or adds something heretofore not available. The authors of this book have attempted, therefore, to present the subject in a concise, brief, overall manner directed primarily to the third year student or busy general practitioner. Consequently a great deal of information is covered in a short space which allows only a cursory review of any particular topic.

The basic format is similar to other texts starting with a review of the morphology, maturation, and metabolism of the blood cells. This is followed by a short survey of 1) various types of anemias, 2) blood coagulation, 3) diseases of the white cells, and 4) a final chapter of hematological techniques. Brief case reports are presented to illustrate the various syndromes which unfortunately cannot show the protean manifestations of any of the disease states described and do not appear to add much to the overall value.

This book does have the advantage that it is up to date on many of the newer concepts in hematology such as the pathogenesis of various anemias, diagnostic techniques, and more recent modalities of therapy which are not included in older texts. It would seem to fill a limited need as a complete outline for students beginning clinical medicine and allowing them to get a general perspective. For a practitioner interested in a particular phase of hematology, however, it would appear to be too sketchy.

Charlton deSaussure, M. D.

CURRENT THERAPY—1961 Edited by Howard F. Conn, M. D. 806 pages. W. B. Saunders Company. 1961. Price $12.50.

This, the thirteenth yearly edition of *CURRENT THERAPY*, is again an extremely helpful and informative review of the most up-to-date regimens in the treatment of various disease entities. The consulting editors are recognized authorities in their fields and do a splendid job in organizing their various sections. The problem of space results in only brief abstracts of various modes of treatment, but sufficient to be of value to the practitioner. It would seem that some subjects, such as hemorrhoidectomy, are too lengthy in that six pages for this subject versus only three pages for hepatitis is not a good division. Also, more space is devoted to treatment of skin diseases than to diseases of the cardiovascular system, which is not felt to be justified, in view of the relative incidence and importance of the two.

Normal limits of laboratory value are very helpful to have on hand, though occasional errors are noted—such as the value for the mean corpuscular hemoglobin concentration of the red blood cell, which is by mistake listed as 27-32 grams instead of in percent. The appendices give further helpful information of the drugs discussed and conversions for pediatric dosages.

This book can be highly recommended to every practitioner as a rapid source of information for newer methods of therapy.

Charlton deSaussure, M. D.

A SYNOPSIS OF CONTEMPORARY PSYCHIATRY, 2nd Edition, by George A. Ulett, M. D., and D. Wells Goodrich, M. D. The C. V. Mosby Co., 1960, St. Louis; $6.50, pages 309.

This synopsis on contemporary psychiatry is unusual in that it is brief enough to be classified as a synopsis and it is informative enough to be of value not only to the student or house officer, for whom it is planned, but also for any physician interested in this medical specialty. It is a happy balance between so-called organic psychiatry, and psychoanalysis.

The synopsis is well organized into the individual chapters. The index is adequate. Although the price of the book seems to be out of line for its size, it is a much more useful introduction to psychiatry than the usual standard textbook which inevitably is bogged down in theory. The book fills well the role indicated in its title.

Wm. C. Miller

RECOGNIZING THE DEPRESSED PATIENT by Frank J. Ayd, Jr., M. D. Grune & Stratton, New York, 1961. 135 pages, $3.75.

This is a very handy, simplified and clarified book on the depressed patient, with an emphasis on the essentials of management and treatment. The main emphasis in the book is on the prevalence of various degrees of depression in the total medical picture. It is very detailed in the presentation, not only of the types of depression, but in the basic ideas of what a depression really is. The author emphasizes the fact that a great many depressives may be easily overlooked because of the dominance of the physical symptoms that may be persistent for several weeks or several months. As in all other medical type problems, the author emphasizes the importance of early diagnosis because of the simpler forms of treatment that are available today to blunt out the effects of depression, which can be very severe and lasting if allowed to go on undetected.

There is considerable discussion on the various theories, both organic and psychogenic, concerning depression and considerable differential review with other types of psychiatric problems, notably the wide variety of anxious type of patient.

Although the book tends to be, perhaps, a little too weighty on the descriptive side, it, however, has a good deal to offer in simple clinical understanding. For example; There is an excellent review of the type of questions that can be asked, in a relatively short time, that can point very clearly to a differential from the anxiety patient and as well from the psychosomatic patient. The main weakness of the volume, although not too important generally, centers on a deeper

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Public Relations

EVALUATING THE CASE AGAINST SOCIALIZED MEDICINE

BY

DR. WILLIAM DE MOUGEOT

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When some of my liberal friends heard that I was going to address a meeting sponsored by the American Medical Association, they urged me to "give 'em hell." I told them I wasn't running for President, and that while I was not going to Chicago to praise the AMA, I wasn't going there to bury them either. Not that I haven't reason to be mad at the medical profession. After all, the first thing that happened to me when I came into the world was that a doctor grabbed me by the feet, held me upside down stark naked, and slapped me on the bottom. Now was that any way to treat a college professor?

But I'm not mad at the medical profession. I say this because in the next few minutes you may suspect that you've got a Trojan horse in your midst. During the first part of my talk, many of you will be tempted to perform a headectomy on me. You see, as a student of argumentation—and I'm a student as well as a teacher in that area—my study of the arguments used by the medical profession in opposing compulsory health insurance have led to the conclusion that many of them are logically weak, and some of your pet beliefs are in for a bruising this morning. But I want to make it clear that I am *not* an advocate of socialized medicine. When I first began my doctoral dissertation at Cornell (The Argumentation in the National Health Insurance Movement) my inclination was to favor the proposals of the Truman administration; by the time I had completed my research, I was convinced that we ought not to adopt national health insurance.

However, it was not the arguments of the AMA that changed my mind; in fact, they often irritated me. It's rather significant that when the subject of compulsory health insurance for all citizens was being debated by the nation's colleges last year, the arguments which most frequently appeared in AMA literature were seldom used by the negative teams; they soon found that those arguments, with a few exceptions, could not withstand an informed, intelligent attack.

My purpose today, then, is to share with you my observations of the arguments most used by the medical profession, in order that you may perceive the weaknesses and the strengths, and the potentialities for improvement, because, after all, we share a common goal—to solve the medical care problems of the American people without resorting to a system of socialized medicine. So when you feel like getting out the tar and feathers, forebear! Soon thereafter I'll be offering constructive suggestions. And remember, my analysis is primarily in terms of the logical validity of the case. The logician asks: How does an argument fare when subjected to the tests of evidence and reasoning—or to intelligent opposition? Many an argument that is logically weak should still be used when the audience is relatively uninformed, or when there is no opposition, because it may produce a favorable emotional response, which is often more effective than logical agreement.

First, I'm going to discuss some of the most commonly used arguments, pointing out the strengths and weaknesses of each; then I'll suggest some things you might do in both selection and use of arguments to present a better case when rational, rather than emotional, appeals seem to be in order.

Many of the arguments most commonly used are what we call "scare" arguments; they depend for their effectiveness not so much on their logical validity as on the emotional reactions they produce.

Typical of this category is the contention that national health insurance will be a step toward socialism. The assertion itself can't be denied and for those people who automatically reject anything bearing that label, this is a potent argument. The very name "socialized medicine" has been a big help in prejudicing the public against compulsory health insurance. Fortunately for the medical profession, most of the American people do react to that label. As John Galbraith points out in his book, *The Affluent Society*, our standard of living, for even the so-called lower classes, has risen to the point where we look with suspicion on anything that constitutes a change in our way of life. The fear of Russia adds to the potency of this argument.

For more sophisticated people, however, this argument has much less appeal. It's the most flagrant sort of propaganda—name-calling—and it has long since lost its respectability because conservatives have applied the label to almost all social legislation. Public education, social security, and minimum wage laws

Delivered at The American Medical Association Institute August 31, 1961, Chicago, Illinois.

have all borne the label; and while the unthinking person may reject compulsory insurance as "socialistic," you will frequently have to prove that this particular step is bad for other reasons.

A second argument that fits this category is that the federal government will control medical care and both patient and doctor will lose freedom. The American people quite rightly treasure their freedom and this argument, too, works well as long as it isn't subjected to close scrutiny. It has the additional virtue of being at least partly true, in that regulations to prevent abuses of the system would be inevitable and where there is regulation, there is irritation.

Well, what's wrong with it? First, in foreign countries and in virtually all proposals in this country, medical matters are in the hands of medical men—and any other system deserves to be opposed. That's one of the big objections to the King bill—it doesn't guarantee that the medical profession will control medical matters.

There are cases in which economy has limited freedom somewhat, but very rarely has it been shown that these restrictions affected the quality of care given. Second, it simply is not true that national health insurance would deny the patient free choice of physician. Of course, not everyone could have the best doctors, to prevent overloading; but does the average person have that privilege now? Economic barriers intervene. I might have preferred to have Dr. Spock as my pediatrician, but I couldn't afford him. Specialization frequently puts patients in the hands of doctors they don't know and they didn't select. But more important, let's look at the precedents: Harry Eckstein states in his book, *The English Health Service*, "No Health Service patient is compelled to go to any doctor but the doctor of his choice, no doctor is compelled to take on any patient he considers undesirable, and patients may switch doctors." While that statement is not 100% true, the essence of it is repeated by Ronald Winton in his description of the Australian system in the *British Medical Journal* of July 5, 1958. And that article goes on to say, "There is no state interference in where or how a doctor practices, provided he observes the usual ethical and legal requirements."

The point I'm making here is that this is a good argument with which to scare people, but you'd better not use it if you have an audience, or an opponent, who knows how foreign systems are run.

Let's take another popular AMA argument—that the quality of medical care will deteriorate. This is usually attributed to the overcrowding of doctors' offices, making it impossible for them to make adequate diagnoses or give proper care. I'm going to surprise you by telling you that that's a rather good argument. Of course it's true that much of the rush to the doctor that took place in Britain when they adopted their system was due to the backlog of real illnesses and needs that had accumulated when people felt they couldn't afford the care, but no complaint by English physicians has been so constant and so well documented as that against the unnecessary calls, and the arbitrary demands and time-consuming paper work. Anyone who knows the American people knows that they'll abuse any system which seems to offer them something for nothing. Doctors have hypochondriacs now, but the privilege will no longer be restricted to the wealthy. Add those who will run to the doctor with every trivial problem, and those who really have put off needed care for economic reasons, and you have an inevitable large increase in demands. If the number of doctors remains constant, simple arithmetic tells you that some of them are going to be rushed; if the number of doctors increases a lot, there is likely to be a reduction in the caliber of person practicing medicine—either way you lose some quality.

However, be prepared for some argument on this point. In the first place, the person who has put off needed medical care because of costs will prefer second rate care to no care; secondly, there is much to be said for the preventive value of frequent visits to the doctor. In Britain, while 79% of the doctors complained of frivolous calls, 71% felt that the system helped them to head off serious illnesses. I could cite many testimonials that the problem of malingering is not serious in Great Britain, and one of the more objective surveys of Britain's system, made by Dr. Paul Gemmill, a professor of economics at the University of Pennsylvania, found that only 13% of the patients questioned felt that care was of poorer quality under the national system, while 37% said they were getting better care. People from England to whom I have spoken all concur; quality of care is satisfactory.

A common error in using this argument is to compare American care with British, and conclude that care had deteriorated there. We have far more doctors per 100,000 population; we have better food and housing; British doctors have always been rushed, and the care in Britain has never been as good as ours. When you compare British medicine before they introduced the national health system to what it is today, you get a picture quite different than when you compare it to American medicine.

The argument that such a system will be expensive is another that has much truth to it, and can be effective if not exaggerated. The British, the New Zealanders, and others are finding the system to be more expensive than anticipated, and quite a drain on the treasury. We now spend 5.2% of our gross national product on medical care; imagine what it will cost to give complete care to all, plus the unnecessary demands.

But again, a few words of caution. For all the talk of high costs, Britain spends only 4 to 4½ of its national income on the health service to give complete care to all, while we spend even more for much less care quantitatively, and their percentage is going down while ours is rising. They spend $50 per person for a rather complete system, while we spend $114 per person for partial care. Furthermore, costs must be related to what's purchased. You might object to

paying $10 to obtain a date for the evening, but not if you got Marilyn Monroe. In Britain, a medical tragedy is no longer a financial disaster and you can't put that feeling of relief into dollars and cents.

A third caution: In a debate, don't treat the taxes which support such a system as if they would be an *additional* burden on each American; most such taxes would merely replace what is now spent on medical care, but under other names. Finally, beware the common assertion that the health dollar would be largely wasted on bureaucratic expense. The overhead for Social Security is 6%; Britain estimates it costs 12¢ per dollar to run its system. Compare this to the average expense of 25%, including profit, of private health insurance.

In 1958, voluntary plans, including Blue Cross and Blue Shield, took in 5.9 billion and distributed 4.7 billion in benefits; 20% went for something besides medical care.

Ultimately, many of the scare arguments against socialized medicine come down to saying that it has failed in foreign nations and therefore we should avoid it here. As you may have noticed from some of my preceeding statements, this argument is not entirely valid. It reminds me of the person who declared to a surprised press conference, "The reports of my death have been grossly exaggerated." There is no doubt that there have been complaints, expenses, difficulties. It's easy to find evidence that national health insurance is not an unqualified success. It's quite another thing to argue that it has failed. There are demands for reform, but seldom for abolition, of the system. I wonder if it has ever occurred to the members of this audience that the United States is the only major nation in the world that does *not* have a national compulsory system of state payment for medical care. If the system is really as bad as it is usually pictured here, would 59 nations have adopted it; Wouldn't at least one abandon it? Wouldn't the conservative party in some nation rally all those discontented people to its cause by proposing to abolish that low-quality, high cost system? The fact is that while individual doctors complain, the British Medical Association accepts it in principle. I quote from articles reprinted in an AMA publication, *The Pill That Could Change America*: p. 13—"Of course, no one wants to see the Health Service done away with." p. 9—from a Conservative member of Parliament: "You know, we do not have a first class, only a second-class health system. However, before 1948 it was only fourth class."

In 1956 the Gallup Poll reported that 89% of the British people interviewed were favorable to the national health system, and surprisingly, almost 60% of the doctors said they found it reasonably easy to give adequate medical care. Ronald Winton reported in his article on Australia, "Despite certain defects, the National Health Service in Australia is working well." The Province of Saskatchewan, Canada, has had a favorable experience with such a system, and as a result, most provinces in Canada have adopted the principle.

Does all of this mean we should join those nations which have some form of state medicine? Not at all, for reasons which I shall discuss shortly. But I'm trying to show you what you're likely to encounter if you assert in an argument with an informed person, that national health insurance has been a failure in other nations.

So far, we've been examining chiefly the arguments with a high emotional persuasive value, useful in situations, such as newspaper advertisements, when the listeners are largely uncritical, and where an informed opponent cannot present contrary information. Let's look at two which form part of the case against socialized medicine that have more logical validity.

One is the contention that it would be compulsory for all, regardless of need. Now that's the kind of thing people resent, particularly in an affluent society, where it's easy to believe that most people can handle their own problems. This argument is strong because it's true—the system would be compulsory for all. Sociologists and economists can demonstrate that a national compulsory system is justifiable and probably cheaper, but it's a difficult line of reasoning to present. To a large extent, arguments for compulsion rest on the objections to a "means" test for charity care, and while social welfare authorities deplore such tests, it's easy to argue that they're better than foisting on *all* the American people a bothersome, unnecessary system.

A second logically sound argument has to do with voluntary insurance as the solution to needs. The smartest move the AMA ever made in fighting socialized medicine was to change its policy in 1948 from opposition, to enthusiastic endorsement of voluntary insurance. Ever since then, the supporters of a compulsory national scheme have had to cope with the increasing evidence that voluntary health insurance can do the job.

Now don't misunderstand me; I'm not saying that voluntary plans *have* solved the problem, and if you choose to argue that way, you're going to take a beating. There are many statistics available to prove that many people are excluded, that policies have many exceptions, that rates are high for many people. The lower income groups, with the greatest health needs, are least able to afford good policies; very few policies, at any price, give really thorough coverage; the difference between the prices charged for care and the benefits paid by insurance companies often leaves the policyholder with a large medical bill. All in all, insurance last year paid only about one-third of the medical bills incurred by those who actually hold policies.

No, you can't prove that voluntary insurance has removed the need for change. But you *can* argue that it's well on the way. The growth of such insurance has been phenomenal, and I'm sure you've seen statistics about that. If you haven't, the AMA Communications Division would be happy to supply them. Just a few years ago, people over 65 couldn't get a policy;

you couldn't get insurance against dread diseases; one of our staff members ran up a bill of $1000 when his daughter was born prematurely and had to be kept in an incubator—a contingency not covered by his policy. But just a few months later our group policy was enlarged and now it does cover such a case. So as long as you argue in terms of what can be done if we just give voluntary insurance a chance, you're on sound grounds.

Let's turn briefly to two arguments that are frequently used by the medical profession that are so easily answered, they're not worth using against an intelligent opponent.

One is that American medicine is the best in the world. First of all, that's not a reason for rejecting efforts to make it even better. Second, when we consider that Americans are better housed and fed, treated with better equipment, have more doctors, it's not surprising that we're the healthiest nation on earth; but that doesn't prove that our system of paying for medical care is responsible. Even the praise of scientific progress in medicine is no compliment to the fee-for-service system, since almost every medical advance has been made by a person on salary, often a government employee. And despite all this, American medicine is *not* the best by some criteria.

In death rate, we're surpassed by six nations, all of which have health plans run by the government. In infant mortality, we've slipped to 10th, and all nine nations ahead of us have one thing in common—the national government pays for medical care. To be sure, the American people on the whole are the healthiest, but that doesn't necessarily mean that our system of paying the bills is the cause of that health.

Finally, there's the argument that all who seek care will get it. That's true, with rare exceptions. But what it doesn't say is that they can pay the bills which follow. And it's the knowledge that for most people the bills *will* follow, that keeps many from seeking the care they should get.

Well, I've exposed some holes in the case against socialized medicine, but my purpose is neither to debate the topic nor to simply make the case look bad. Remember that most of the arguments we've examined work quite well on most people; it's only when facing more informed audiences, or arguing with an intelligent opponent who possesses some of the facts I've cited that the vulnerabilities I've mentioned become a problem. I sincerely hope that I *have* shaken your faith in some of these arguments, because it may save you embarrassment in some situation where these weaknesses are mentioned and you're unprepared for them. But there *are* ways of presenting a more logical case, so let's examine some of them.

The first problem is to avoid three errors of logic which commonly appear in arguments against socialized medicine: exaggeration, omission, and inconsistency. We frequently use words like *all, only, no-one,* and when we do, the opponent need only cite an example or two to damage an argument which would be perfectly valid if we just said *almost all* or *with rare exceptions.* We're also prone to use statistics loosely. In *The Pill That Could Change America* (p. 6) we're told that a doctor may have no more than 3500 patients, that he's required to see 100 patients a day to make a living, and that he earns about $4000 per year after expenses. But the average load is about 2200, only rarely have doctors seen as many as 100 patients in a day, and more reliable sources list the average income at $7000, after expenses. The real figures are bad enough, so why exaggerate and risk exposure? This particular problem is especially acute when discussing voluntary insurance. Don't claim too much for it. I've already discussed this argument enough to indicate what I mean. There's a big difference between saying 123 million people are covered, and saying they therefore have no medical expense problems; and just because some companies offer good coverage for those over 65 doesn't mean that everyone over 65 can obtain that policy.

About omissions: of course I don't mean that you're obligated to present facts favorable to the other side. What I do mean is that you ought to beware of arguments that depend for their persuasive force on the listeners not knowing the qualifications that apply. This would apply to such arguments as mentioning high costs, when they're traceable to increased care; it applies to comparing foreign care with American care, hoping that no-one will mention that we have all the economic advantages, superior facilities, and more doctors; and it would apply in a case where you discuss the high administrative costs of national plans, hoping that no-one mentions the even higher costs of voluntary insurance.

Now for the inconsistencies: Be sure that two arguments used at the same time don't conflict with each other. For instance, it's a little difficult to say in one breath that doctors have a high sense of professional responsibility, and in the next breath say that if incomes are fixed, doctors will lose the incentive to practice good care.

In the AMA booklet *The Pill That Could Change America,* we find on page 5 the idea that in Baltimore people didn't seek care even when it was offered free, and on page 6 is the observation that doctors in England have been besieged by hordes of patients who aren't really sick. On page 8 we're told that the government requires a sparing use of x-rays, while on page 9 a British nurse is quoted as saying that some of the waste is due to "all those diagnostic x-rays".

In summary, you'll be less vulnerable to opposing refutation if you avoid exaggeration, be careful in your use of arguments that omit some data, and avoid inconsistencies.

My second major suggestion is to play down the arguments that have more emotional than logical appeal, when engaged in debate. Stress the difficulties of foreign nations, instead of claiming their systems are failures; speak of the future of voluntary plans, not of their alleged present adequacy; don't claim that patients will lose their choice of doctors, almost any

well informed opponent will be able to show that that assertion is not quite true.

Conversely, make more use of strong arguments. You can certainly argue that the total cost of medical care will increase, and you can play up the malingering argument. The reaction of the American people to the Newburgh, N. Y. welfare situation, surely demonstrates that most people resent having others abuse charity programs. You can also argue that the healthy will be paying for the care of the ill, an idea that may appeal to social scientists, but it certainly doesn't appeal to the healthy people—which means most people.

It seems to me that you ought to be able to make more use of the idea that it's silly to adopt a massive program for the whole country just to avoid embarassment of a small percentage who don't like to apply for welfare care.

And there is one line of argument which *has* appeared in propaganda against socialized medicine, but with much less frequency than it deserves. I refer to the simple argument that most of the medical expenses we incur, and most of the ones we avoid, can easily be handled within our incomes if we would just readjust our scale of values. That's one argument that kept bothering me as I examined the arguments of those who favor socialized medicine. So many of the alleged needs seemed to boil down to an extra office call, or a matter of a hundred dollars. And I thought of the people who spend $50 on a weekend of fishing while their children's teeth go without care. I even thought of the way I resented my doctor charging double what the Blue Shield allowed for an operation, and then spending twice as much for a second car.

Why, after all, should we adopt a national system for this particular need? How about cars, which have become a virtual necessity, or better housing? This argument is easy to present, because you can find so many familiar illustrations and it's so easy to draw analogies to other needs.

My fourth suggestion for improving the case is to go on the attack more often. A lot of the fallacies mentioned today are also found in the case *for* socialized medicine. They *also* exaggerate and omit and are inconsistent. Be on the lookout for such errors. And remember that he who advocates a change carries the main burden of proof. Challenge the opposition to prove that the needs for a change is *great* enough to warrant this drastic a change. When they show the gaps in our present payment system, see if they can prove that a large percentage of our populace is unable to meet the costs in *some* way. Is the particular need they use as the basis for their case unsolvable by other means? By simply remembering that drastic change requires drastic need, you'll often put the opposition on the spot.

My final suggestion has to do with the entire approach to the problems of paying medical care. For many years, organized medicine has been associated with negativism; that charge is much less justifiable now, but there is still a need to be *for* something more often. I mentioned earlier the change in attitude toward voluntary insurance that occurred when the public relations firm of Whittaker and Baxter took over the AMA campaign against Truman's health bills. They understood the need to say something besides "no" to almost all new proposals. Since then, the medical profession has stood on firmer ground. Supporting the Kerr-Mills bill instead of merely opposing the Forand bill, was the right kind of argumentation. In an address to the Life Insurance Medical Directors in October, 1959, Dr. Louis Orr struck the right note when he urged these men to push policies for those over 65 as the best way to avoid legislation like the Forand bill. More effort by physicians to encourage patients to select good insurance policies would help; you might even have the names of companies offering good plans available for the patient who seeks such information. The only really thorough plan would be one that paid *all* expenses above 6% of a man's income, or everything above $25 in any one illness. There are plans that give coverage that are good—or better—but medical societies are often fighting them as socialistic when they should be pushing them as a better alternative than a national compulsory system.

How about time payments? That's always seemed to me a rather obvious solution for large bills. The American people are used to time payments for almost every large expense, what would happen to the person who doesn't pay his bill because it seems so large, if he could simply pay the bill as he pays for a refrigerator or new golf clubs? I know these are problems, but the dentists in Texas have a state-wide credit system, administered by a bank, which has worked very well for them. My dentist reported that his business had increased, his bad debts all but eliminated, and his relations with his patients greatly improved since he began suggesting this plan to any person with a bill over $50.

Being positive means to put the emphasis on helping to solve problems, not on denying that they exist. And it means improving your image in the eyes of your patients; too many doctors have become so involved in their pursuit of the dollar that they've become impersonal and hurried, and all too often doctors have raised their fees for those who hold health insurance policies, thus defeating the very purpose of having the policy.

There's a lot more that could be said in evaluation of—and improvement of—the case against socialized medicine, if time permitted. But I hope you haven't been so busy resisting my ideas that you've missed my real purpose in giving this kind of talk. I *want* you people to win your fight against socialized medicine because I think we can solve the problems that still exist in paying for medical care without going to the extremes that less wealthy nations felt they had to adopt. But if we're to win the fight, we ought to be anxious to use the most effective weapons. In the face of informed opposition, some arguments that are emotionally strong prove to be logically weak. How-

ever, in such situations, there are other arguments that have logical validity. By using some of those I've mentioned—by taking a more positive approach—by demanding that the supporters of socialized medicine show a *drastic* need—and by avoiding some of the errors of argumentation, I hope you'll be *better* able to present a case against socialized medicine. And then we'll both have done our share in saving our nation from what we both believe to be the wrong solution to the problem of paying the costs of medical care.

(Continued from Page 452)

psychological description of the basic psychodynamic problems encountered in a depressed patient as compared with an anxious patient.

This book makes easy reading and is an excellent book for all practitioners of medicine. It has the special quality of being able to awaken an interest in the underlying psychology of physical symptoms in general.

Norton Williams, M. D.

NON-INFECTIVE DISEASE IN AFRICA. H. C. Trowell, Williams and Wilkins Co. Baltimore, Maryland, Exclusive U. S. Agents, 481 pages, $13.00.

This book cannot be recommended for the general reader. The author excludes infectious, parasitic, and surgical diseases from consideration and discusses by systems what is left over. He attempts to compare many entities as they exist in Africa with the general impression of parallel diseases in Western society. As such, a great deal of space is wasted in repeating descriptions of entities already amply described in many text books. No condition is considered in great detail with the possible exception of some of the infantile hepatic diseases. Nowhere is there intense exploration of the reasons for the differences described between Western and African disease aside from generalizations about diet and parasitism. Except in obvious instances such as the sickling trait, there is no mention of genetics and its role in the emergence of variation in the response of a genetically separate group of people to disease. The treatment of conditions apparently indigenous to Africa, such as vascular diseases, idiopathic cardiomyopathy, various liver syndromes is not detailed enough. Psychic influences are seldom mentioned. Much space is wasted on obvious truisms. The major value of the book would appear to be for the relatively unsophisticated student who is actually on the scene in Africa or who is intending to go there. In addition to this, its bibliography would be of help to the student seeking more detailed information about the incidence and natural history of degenerative disease as it presents itself in Africa.

C. M. Smythe, M. D.

SOUTH CAROLINA MEDICAL ASSOCIATION
MINUTES OF THE
ONE HUNDRED AND THIRTEENTH ANNUAL SESSION
OF THE HOUSE OF DELEGATES

MINUTES CONTINUED
HOUSE OF DELEGATES

Wednesday, April 26, 1961 — Charleston, S. C.
Joseph P. Cain, Jr., M. D., Presiding

THE CHAIR: The Credential Committee reports a quorum is present.

The first order of business today, we will take up the reports of the various reference committees. The first report will be the report of the committee to study the Reports of Council and Officers, Dr. Pierre F. LaBorde, Chairman, of Columbia, Dr. LaBorde.

DR. PIERRE F. LaBORDE, JR.: Your Reference Committee on Report of Council and Officers met and considered the following reports and submits recommendations thereon as follows:

Officers' Reports

The report of the secretary was considered in its entirety and this committee commends the secretary for his effective work during the year and joins him in his recommendation that the State Association work for proper legislative implementation of the Kerr-Mills Bill and keep watchful vigilance on all proposed legislation, state and national, affecting physicians.

THE CHAIR: Dr. LaBorde, read your entire report and if you have any particular recommendation before the report is finished, you make the motion, as you go along whenever you want action taken by the House of Delegates.

Dr. LaBorde (continuing report): The report of the treasurer was reviewed and discrepancy between that presented and that published was discussed and corrected by the treasurer. With a very minor reprimand for minor derelictions in mathematics, we commend his conduct of his office and recommend acceptance of his audited report as published in the Journal.

The report of the editor of the Journal was reviewed. The committee individually and collectively were reminded how eternally we and our association are in his debt for the fine, inadequately assisted fashion in which he serves in this and multiple other capacities and recommended our thanks be conveyed and our hope that more tangible evidence of our gratitude may be forthcoming.

The further report of our editor, in his capacity as chairman of the committee on Public Relations, was reviewed and we commend the committee's efforts in these respects and recommend increasing utilization of the proposals and materials available through this committee.

The report of the President of the Woman's Auxiliary was reviewed and we commend the president and her membership for deeds well done and beg their continued valued valuable support.

The report of the executive secretary was reviewed and we commend the activity in the legislative field and recommend continued vigilance and would like to join our executive secretary in recommending to the membership attention to our exhibitors.

The reports of our delegates to the A.M.A. were reviewed and are commended. We hope our representatives, whoever they may be, will continue to promote our and other proper causes in high places. Particular note was taken of the recommendations presented from Dr. Johnson's A.M.A. committee reminding us that positions may be filled in councils and committees by proposals from state and county societies. We recommend consideration of all our delegates' proposals by appropriate organizations at appropriate times.

Council Report

The portion of the report of Council, referred to our committee was reviewed. We concur in Council's pride in our member, Julian Price, being Chairman of the A.M.A. Board of Trustees and agree to his fitness to hold its highest office. Council's approval of the proposed adoption law, we concur in although specific provisions were not available to the committee.

Dr. Tom Parker's report for Council, recommending subscriptions for council members to "Challenge to Socialism" by Dr. Marjorie Shearon with his commendation as to its being informative and authoritative, was reviewed and further elaborated on by Dr. Tom Goldsmith and the committee agree subscriptions for councilors and such other officers as council decides proper should be procured and we further recommend it to such societies and individuals as may elect, in view of its endorsement by our "heart and conscience of a conservative member."

Those portions of Council's report dealing with appropriations of money to benevolence committee, potential scholarship grants, analysis of salaries paid by the association, were reviewed and we commend Council on these efforts and recommend their continuance at the option of Council.

The motion presented from Council in reference to establishment of a First Aid Station in the State House, as proposed for study by the Columbia Medical Society, was discussed by the committee and with interested members. It was the unanimous opinion that no such study be undertaken. The potential good public relations, as was mentioned in the resolution, was noted but thought to be far outweighed by potential bad and other undesirable features. It is therefore the recommendation of this committee that no such study be undertaken.

This completed the report of the Reference Committee.

THE CHAIR: Thank you, Dr. LaBorde.

Motion was made that the report be accepted, seconded, not discussed, the vote was taken and unanimously passed.

Dr. George Wilkinson, Sr., is now present. I wonder if he would like to give a short report of the work of the State Board of Medical Examiners at this time or if he has any comments? This is out of order but we are all interested in the State Board of Medical Examiners and I would like Dr. Wilkinson to have the floor for a few minutes at this time.

DR. WILKINSON: I have no report to make.

THE CHAIR: It is just as well that Dr. Wilkinson left yesterday, he says he doesn't have anything to say.

Legislation and Public Relations

The next report will be the Reference Committee Report on Legislation and Public Relations, Dr. Ripon LaRoche, Chairman. I would like to ask Dr. LaRoche

whatever recommendations he has we will pause at the end of each one. We will not consider the report as a whole but will take it up individually. Dr. LaRoche, Camden.

DR. LaROCHE: Mr. Chairman and fellow delegates, the Legislation and Public Relations Reference Committee met in open and closed session, and presents the following recommendations:

(1) It is recommended the report of the Committee for Legislation and Public Policy, as submitted in the *Journal*, be accepted. I move the acceptance of this recommendation, Mr. President.

(This motion was seconded by Dr. Thomas R. Gaines, there was no discussion, the vote was unanimous and it was so ordered.)

(2) It is recommended further efforts be made toward establishment of a Medical Examiner—Coroner System in South Carolina. It is also felt a greater degree of public education toward this goal be instituted. I move the acceptance of this recommendation, Mr. President.

(This motion was seconded from the floor, the Chair called for discussion.)

THE CHAIR: Does the Chairman of that committee want to explain his recommendation that it be abolished? As I understand it, Dr. LaRoche, your recommendation is contrary to the recommendation of the committee?

DR. LaROCHE (Chairman) That is right, sir. (The vote was taken and passed and it was so ordered.)

(3) It is recommended by this committee that the present established system for obtaining certified copies of birth certificates be considered adequate and due to costs, difficulties and other measures any change might incur some further difficulty; it is felt, further, since the mother now certifies the present certificates, such copies are unnecessary as a means to avoid mistakes of information given on such certificates. Mr. President, I move the adoption of the recommendation of the committee.

(This motion was seconded from the floor, there was no discussion.)

THE CHAIR: The motion is that the present birth certificate system be continued with no change. (The vote was taken and unanimously passed and it was so ordered.)

Reregistration

(4) The last resolution discussed was the resolution presented by the Aiken County Medical Society entitled Medical Practice Act of South Carolina, as amended (and further amended)—contains no threat to the privilege of *Licensure*. Further, it does not give the Board of Medical Examiners any additional powers or authority, not already delegated to it, to revoke a license.

Licensure is automatic with payment of the authorized fee.

Your committee feels favorably inclined toward this bill. However, it also feels many delegates have been instructed to oppose a re-registration act as originally presented and passed by the House of Delegates, due to certain provisions both contained or omitted; therefore, the Committee deems it to be wise that the present resolution, as proposed, be submitted to the membership units of the South Carolina Medical Association for a referendum or reconsideration should the action of this assembled body be unfavorable. The Committee, therefore, recommends the adoption of the Aiken County resolution and that recommendation failing we recommend the referendum.

THE CHAIR: The motion is that the resolution as presented yesterday morning by Dr. George A. Poda, of Aiken, be accepted by this assembly. He has moved its adoption, is there a second?

(This motion was seconded by Dr. Poda)

Is there any discussion on the motion? Now, gentlemen, I am going to pause a minute, I don't know whether the Chairman moves to railroad it through or not, this is re-registration, as you know, and I certainly don't want us to pass something now and next week be on our toes to get it off. Does everybody know what they are voting on? Are you ready to proceed?

DR. J. P. BOOKER: Mr. Chairman, is it proper for this resolution to take precedence over a resolution that has already passed and is being held in abeyance until this meeting?

THE CHAIR: That is the prerogative of the committee. The other resolution was sent to the committee. Apparently they have disposed of it and favor this other.

DR. LaROCHE: No, we did not have the other resolution, I think we all understood that.

THE CHAIR: In other words the subject of re-registration was referred to your committee and this is your report on re-registration?

DR. LaROCHE: That is correct.

THE CHAIR: What about the resolution from Anderson County that the re-registration resolution be tabled?

DR. LaROCHE: The Anderson County Medical Society resolution was discussed very briefly and nothing was done about it.

THE CHAIR: Well, the fact is you can't bring in but one resolution for it and also recommend one against it, so you have brought in one for it. Apparently the Anderson County resolution was not acceptable.

DR. LaROCHE: That is correct.

(From the floor) Mr. President, in his resolution he refers to a referendum. If it is the concensus of this committee that this resolution be adopted by the House of Delegates—then what provision is being made for a referendum of the state Medical Association?

THE CHAIR: As I understand his recommendation it is this, that if this motion fails he recommended that it be referred to the counties, is that correct, Dr. LaRoche?

DR. LaROCHE: That is correct, yes, sir.

THE CHAIR: In other words, he is one jump ahead of the House of Delegates. If you pass it, then you have got it. If you don't pass it, then his committee requests a referendum. That is the resolution, is it not?

DR. LaROCHE: Might I explain, this meeting of ours lasted almost three hours, last night. We had the pros and cons, the discussion for this and after the discussion we felt the balance of power was very little on either side. After thinking about this considerably we felt that enough men in our state of the medical profession do not even realize what this act is, they have had no chance to see it, and we felt that if this bill could be passed by the house it was a good bill. However, we felt if it was unfavorable we still think it might be turned back to the individual county societies for a full referendum vote and get the will of the entire S. C. Medical Association.

THE CHAIR: In other words, if the bill passes then you recommend the referendum, anyway?

DR. LaROCHE: No, sir.

THE CHAIR: Is there any further discussion?

DR. BOOKER: I make a motion that this resolution be tabled.

THE CHAIR: Motion has been made that the resolution be tabled.

DR. GAINES: I second the motion.

(There followed considerable discussion of the nature of the resolution and the method of voting.)

THE CHAIR: The vote to table has carried 51 to 43. (A tabulation of the vote appears in the original minutes.)

I would like to go ahead with the rest of the report

on Legislation and Public Relations at which time we will entertain any motion for or against re-registration. Dr. LaRoche, will you continue your report, please.

DR. LaROCHE: I would like to make another motion. I would like to move that this amended resolution of Aiken County, as amended, be referred to the County Medical Units of the S. C. Medical Association for a referendum vote.

(This motion was seconded from the floor by Dr. Atwill.)

DR. GOLDSMITH (Recognized) Is he making that motion as an individual or as a member of the Committee on which he serves?

DR. LaROCHE: As an individual.

THE CHAIR: If it is made individually it is out of Order.

DR. LaROCHE: Excuse me, please, I am making this as a recommendation of the Reference Committee.

DR. GOLDSMITH: The Reference Committee does not have the prerogative to bring in anything except a rejection or a reception of a resolution. So that is out.

THE CHAIR: I would differ with that, I think the Resolution Committee can arrive at any compromise that they think might be acceptable, that is the reason for their work. However, I would like to call for a vote on this to get it clarified. If anyone objects to my ruling I would be glad to call for a vote from the house to either sustain or reject it. I would like to get this thing cleared one way or another, and the motion has been made and seconded that this be sent to referendum. If you don't want to do it, let's vote it down and clear the slate, if you want it let's do it. Is there any discussion on that motion? If not all in favor say "aye" (Many ayes) All opposed "no". (Many noes) We are right back where we started.

Doctor on the Floor (Recognized): To save time, if Dr. LaRoche will accept a substitute motion. I understand he voted against tabling the motion, therefore his motion might not have passed because of that, I voted for tabling the motion, wouldn't that put me in the position of putting in a substitute motion if Dr. LaRoche would accept it?

THE CHAIR: Dr. LaRoche's substitute motion was accepted.

(The Doctor) I was thinking we were voting if we were sustaining you in your motion for an order?

THE CHAIR (Laughing) Thank you for that vote of confidence. I was not going to put that to the House. Dr. Goldsmith was not pressing the point. What is the opinion of the House?

DR. EADDY: We respect your ruling. I withdraw mine. What was it on?

THE CHAIR: The vote was on the motion, in other words, the vote is that this amendment be sent to the various County Societies. Now, that, of course, is contingent on any action which you may take after this substitute if you consider any other form of re-registration for which the floor will be open right now. Is there any other motion concerning re-registration or the reconsideration of re-registration?

DR. WILSON (Interrupting The Chair): Pardon me, but you have not ruled on the vote of Dr. LaRoche's motion?

THE CHAIR: Yes, I have, I ruled it was carried.

DR. GOLDSMITH (Recognized): A good many are in favor of re-registration and a good many are opposed to re-registration. I would like to make a motion that Council, itself, study the matter and bring in an entirely different or a properly drawn up document to be presented at the next year's meeting and at the same time to be presented to the various county societies before that. (Seconded from the floor)

THE CHAIR: You have heard Dr. Goldsmith's motion. I call your attention to the fact that you have already just said the Aiken County resolution would be sent to the County Societies for approval or rejection. Do you mean that that should take precedence over the other, do you reconsider the other vote?

Gentlemen, you have heard Dr. Goldsmith's motion that council consider and bring in recommendations next year as part of the plan on re-registration and before it is brought in to present it to the counties, is that correct, Dr. Goldsmith?

THE CHAIR: And that that report shall be in addition to the Aiken County Report which has already been passed by this house today subject to County referendum, is that correct? Is there a second to that motion?

(The motion was seconded.) Is there any discussion?

DR. DUNCAN recognized: Dr. Cain, I am speaking as an individual and not for my county, but it seems to me we are just making and passing a lot of motions and not accomplishing anything. I would like to hear just a little discussion as to why some people object to re-registration. We have had this very problem in our time before, a physician came into the county and there was no way of finding out if he was registered or not except that we write to the State Examiner. We did not have any ready reference. I am licensed in Georgia also and in Georgia they require re-registration every year. It is no trouble at all, they mail us a statement at the end of the year, we sign it and mail it back and they send us at the first of the year a complete listing of every physician in Georgia, where he is practicing, what type practice he does and everything. I don't understand the reason for objecting to re-registration. It seems to me we are wasting a lot of wind just saying "yes" or "no". If there is any reason not to register a good many would like to hear one reason for not re-registering. There is nothing that says it affects your license, it is not re-licensing, it just tells where you are, what your type practice is and if you move out of the state where you are located. It is strictly for our own information, no one else has anything to do with it. I don't understand the objection. If anyone objects to this and has any particular reason, then I would like to hear from him.

THE CHAIR: Before we get into a haggle of "yes" and "no" we will have to have a different motion on the floor because we are not discussing the motion on the floor, the motion is Council study this and bring in a plan next year and before they bring it in it will be submitted to the counties, along with the Aiken plan which will also be submitted to the counties. Now, that is the motion, we are going to dispose of that motion, then if anyone wants another motion and discuss it, we will then discuss it until dinner time.

All in favor of Dr. Goldsmith's motion say "aye". (A good many "aves") All opposed "no". (There was a preponderance of the Noes.)

Dr. Goldsmith's motion fails.

THE CHAIR: Gentlemen, are you through with re-registration, as of now, until the report comes in next year whereby the motion to consider the Aiken County Resolution, if any County Society endorses it. There is no mandate to the House of Delegates to consider it, the only mandate is that it be sent to the County Societies for referendum. Next year Charlie Wyatt can argue with you.

I hereby declare that re-registration is over for this year.

Public and Industrial Health

THE CHAIR: I will now call for the report of the Reference Committee on Public and Industrial Health, Dr. P. K. Switzer, Jr., Chairman, Union. Dr. Switzer.

DR. P. K. SWITZER: (Reading) Mr. President, The Reference Committee on Public and Industrial Health met and considered the following reports and resolutions:

(1) The report of the Medical Advisory Committee to Crippled Children, the reference committee recommends that this report be received and adopted by the House of Delegates, and I so move. (This was seconded, the vote taken and the motion carried.)
(2) The report of the Committee on Rural Health, the reference committee received that report as information and moved that the report be adopted and I so move. (This was seconded, there was no discussion, the vote taken and the motion was adopted.)
(3) The report of the Committee on Industrial Medicine— the reference committee received that report as information and moves the committee report be adopted by the House of Delegates. I so move, Mr. President. (This was seconded)
THE CHAIR: Any discussion?
DR. JOHNSON: What is it about?
DR. SWITZER: It is printed in the brochure there, Dr. Johnson.
THE CHAIR: All of these reports have been printed.
DR. JOHNSON: Is the adoption anything we have to do or do we receive it as information?
DR. SWITZER: We receive it as information and adopt their recommendation.
(The vote was taken and passed.)

Care of The Aging

(4) The Committee Report on Care of the Aging— the reference committee approves the report as read with the exception of Section 4, which recommended "that the council contact Drs. Peeples and McDaniels." We move to have that stricken out and substitute "that the council contact the Executive Committee of the State Board of Health requesting them to implement the program as recommended." I so move, Mr. President. That simply eliminated the names of "Drs. Peeples and McDaniels" who say that the executive committee would have to act on that. (The motion was seconded)
THE CHAIR: What was the program they wished?
DR. SWITZER: The Pilot Program for home nursing care, which they wished to implement and speed up, with the hope that such a program can be established in every county in the State.
THE CHAIR: The motion has been made and seconded, is there any discussion? (There was none, the vote was taken and it was carried.)
(5) The Report of the Executive Committee of the State Board of Health—the reference committee received this report and moved that it be adopted by the House of Delegates. I so move, Mr. President. (This was seconded, there was no discussion, the vote was taken and passed and the report adopted.)
(6) The reference committee concurs in the resolution of the Public Health Committee and recommends that the committee be dissolved. I so move, Mr. President. In view of the fact that the Public Health Committee apparently overlaps the report of the Executive Committee of the State Board of Health, they have recommended that they be dissolved and not function anymore and we concur in that recommendation and so move, Mr. President.
(This motion was seconded)
THE CHAIR: Gentlemen, the motion is Committee on Public Health asks that it be abolished; the reference committee reports favorably and so moves. All those in favor say "aye".
DR. ROBERT WILSON (interrupting) Mr. President, that is one of the Standing Committees of the House in the By-Laws and I think that would have to be taken up by an amendment to the By-Laws, rather than in this manner.
THE CHAIR: That is a Standing Committee of the House?
DR. SWITZER: This same report has been carried for two or three years that this be abolished, and that is the only report they have ever made.
THE CHAIR: Just a moment and we will get a parliamentary ruling, to see if the committee can be abolished. (Mr. M. L. Meadors, Executive Secretary, is called for a ruling.)
THE CHAIR: Mr. Meadors, a resolution by the Committee on Public and Industrial Health referring to a report on the Committee of Public Health, which recommended that its own committee be abolished, since it overlaps the Executive Committee of the Board of Health, however, that is a Standing Committee in our By-Laws. Dr. Wilson raises the point of order as to whether or not it can be abolished by vote. I do not believe that you have to have any special order, it is a question of voting "yes" or "no".
MR. MEADORS: It would simply be an amendment to the By-Laws which would take a two-thirds vote. It can be voted on.
THE CHAIR: The recommendation can be voted on.
THE CHAIR: All right, gentlemen, we can vote on this motion but it will take a two-thirds vote of those present to carry it since it is an amendment to the By-Laws. We will now vote to amend the By-Laws by removing the Committee on Public Health from the By-Laws. All in favor, please stand up. All opposed, please stand up.
The necessary two-thirds having voted, I declare the By-Laws amended to remove the Committee on Public Health.
(7) The report of the Civil Defense Committee—the reference committee wishes to congratulate the Richland County Medical Society on its efforts for emergency medical services and recommends that other counties take similar action.
This is not made in the form of a resolution but was simply a small copy of what the Richland County Delegation or the Richland County Medical Society has done in an effort to prepare for emergency action.

"Doctor, lately I've noticed that I tend to put on weight and feel anemic and have increased susceptibility to infection and have an accumulation of fluid under the skin that resembles an edema-like state and see also page 714, cretinism, tend to lose hair and have dry skin and a lowered rate of body heat production and . . . ."

We accept it as information and wish to congratulate them on their efforts.
(8) With reference to the resolution proposed by Dr. George D. Johnson with reference to automobile accidents, this committee concurs and moves that the resolution be adopted by the House of Delegates. I so move, Mr. President. (Motion was seconded.)
THE CHAIR: Does that have to do with cooperating with the Cornell Board on Accidents?
DR. SWITZER: No, this had to do with sending memorandums to the Chairman, State Highway Commission, and to the State Legislative Commission urging them to take appropriate action and make legislation to urge magistrates to impose stiffer fines and to be more stringent in enforcing our laws in an effort to do away with drunken driving. It was the resolution submitted by Dr. Johnson yesterday.
(There was no discussion on the motion, the vote was taken, passed and it was so ordered.)
DR. SWITZER: I move that the report be accepted as a whole, Mr. President.
(This was seconded, there was no discussion, the vote was taken and passed. It was so ordered.)
THE CHAIR: The next report will be the Reference Committee to Amendments to Constitution and By-Laws, Dr. Frank Owens, Chairman, Columbia.
DR. FRANK OWENS: This committee has several amendments that they considered and I presume that the same ruling would apply to these that applied to the other a few minutes ago, because they are all amendments to the By-Laws.
First let me say the published Constitution and By-Laws are dated 1957 and since then there have been two or three amendments and the numbers are "A" or "B" or "1" and "2" or something like that, and may not exactly fit in, but the intent of our recommendation is that the proper numbers be placed in front of the proper paragraphs.

Committee on Scientific Program

(1) The first is the Committee on Scientific Program shall consist of three (3) members together with the president and secretary, ex officio. The said three members shall be appointed by the President initially, one for a term of one year; one for a term of two years and one for a term of three years. All terms following the initial term shall be three years. The committee shall determine the character and scope of the scientific program of the general sessions of the Association and select the speakers subject to the instructions of the House of Delegates or Council. Thirty days prior to each Annual Session, it shall prepare and issue the official program of the meeting.
The change from the old one over this is that the former rule did not specify as to who appointed the committee on the program nor did it specify any particular length of time. The result is that perhaps a man serves one year or he might serve ten years, so this specifies the time.
(motion) Your reference committee recommends the adoption of this and I so move. (This was seconded by several)
THE CHAIR: Gentlemen, this is an amendment to the By-Laws which requires two-thirds vote, and you will vote by standing, please. All in favor please rise. All opposed, please rise. (It was unanimous) The vote is carried by the necessary majority.
DR. OWENS: The next:
Amend Chapter VIII, Section 3 of the By-Laws by adding at the end of the list of committees therein, another committee to be designated as follows:

Committee on Emergency Medical Care

Amend Further By Adding In Chapter VIII a new section, immediately after Section 11, to be numbered Section 12 and by renumbering the remaining sections of said chapter to conform, the new Section 12 to provide as follows:
The Committee on Emergency Medical Care shall consist of five (5) members nominated by Council and elected by the House of Delegates. Initially, one of such members shall be nominated and elected for a term of one year, one for a term of two years, one for a term of three years, one for a term of four years and one for a term of five years.The terms of all members of the committee following the initial terms shall be five years. The committee shall organize at the first meeting by the election of a chairman and a secretary and such officers shall be chosen by the committee annually.
The committee shall be charged with the responsibility for study, planning, and advising the Association with respect to the medical phases of civilian defense and disaster medical care preparedness, and to act as a liaison between the medical profession of South Carolina and the Director of Civil Defense.
This is a new section and does not substitute any other section. The Committee recommends approval anl I so move. (This was seconded from the floor).
THE CHAIR: This amendment required a two-thirds majority and that number voting for it I declare the amendment adopted.
DR. OWENS: Next:
Amend Chapter VIII, Section 3, of the By-Laws by adding at the end of the list of Standing Committees another to be designated as follows:

Committee on A. M. E. F.

(11) Committee on American Medical Education Foundation.
Amend the said Chapter further by adding another Section immediately after Section 13, to be numbered Section 14, and by renumbering the sections of said chapter to conform. Said section to read as follows:
"The Committee on American Medical Education Foundation shall consist of five (5) members, three (3) to be appointed by the President of the Association, the President and Treasurer of the Association, ex officio. The three (3) members to be appointed shall serve initially one (1) for one (1) year, one for two (2) years and one for three (3) years, as designated by the Chairman of Council. The terms of all members thereafter appointed shall be three (3) years. It shall be the duty of this Committee to supervise the conduct of all publicity and fund raising for A. M. E. F., to receive the reports from A. M. E. F. together with the remittance of such funds as may be allocated for the Medical College of South Carolina, to transmit the same to the Dean of the School of Medicine, Medical College, and to receive from him reports and information concerning the application of the funds so received. The Committee shall act in all respects as the connecting link between the Association, the American Medical Education Foundation and the Medical College of South Carolina. Its chairman shall be elected annually by the committee."
There was one question brought up in discussion before our committee and that was if a doctor wanted to designate the $10 that he sends in to be used at some other school could he do so and does this affect it anyway. It does not affect it in any way. If you do not designate it be used somewhere else it will automatically be used by the Medical College of South Carolina.
Your committee recommends the adoption of this resolution. (This was seconded) The Amendment was adopted.

Committee on Welfare and Rehabilitation

DR. OWENS: The next and final recommendation has to do with the Committee on Welfare and Rehabilitation. There is at present a committee set up on Welfare and Rehabilitation and it was felt by some that it would be better to be separated and made two committees, as a former section of our By-Laws put both together two motions are necessary. One is to take

the Welfare out of the "Welfare and Rehabilitation" and the other setting up the "Welfare Committee". So, I will read you the old one first, and show the changes there, and then go to the recommendations.

Amend Chapter VIII, Section 3, by adding at the end of the list of committees there stated, the following:

It now reads:

(9) "Committee on Welfare and Rehabilitation" strike out the words 'Welfare and' so that it will read "Committee on Rehabilitation."

The Committee on Rehabilitation shall consist of five (5) members appointed by the President of the Association. Initially the terms of office for one year, two, three, four and five years, respectively, as designated by the President at the time of appointment, so that the term of office of one member of the Committee shall expire each year. The terms of all members of the Committee following these initial terms shall be five years each. Yearly regular vacancies occurring by the expiration of a member's term, and vacancies occurring by resignation or otherwise shall be filled through appointment of the President. The Chairman of the Committee shall be elected by its members annually.

This Committee shall have the responsibility of advising and maintaining liaison with the several agencies in the field of rehabilitation. The Committee shall keep the Association cognizant of the needs and accomplishments in this area of responsibility through annual reports and interim reports when necessary or desirable.

THE CHAIR: We will vote on them individually, but I wish you would read them the other one, then we will have the whole before us.

DR. OWENS: I will read the second one, then we will submit the first one for your approval or rejection. The second one is:

Amend Chapter 8, Section 3, of the By-Laws by adding at the end of the list therein another committee to be designated as follows:

(10) Advisory Committee to the Department of Public Welfare.

Amend further by adding in Chapter 8 a new section immediately after Section 12 to be numbered Section 13 and by renumbering the Sections of said Chapter to conform. The new Section 13 to read as follows:

Advisory Committee to The Department of Public Welfare

The Advisory Committee to the Department of Public Welfare shall consist of nine (9) members, one from each medical district to be appointed by the President. Initially, three of such members shall be appointed for a term of one (1) year; three (3) for a term of two (2) years; and three (3) for a term of three (3) years. The terms of all members of the Committee following the initial terms shall be three (3) years. It shall be the duty of this Committee to consider, when requested, any matters concerning the practice of members of the Association involving patients under or programs of the Department of Public Welfare and to attend as a liaison between the Department and the Association.

The members of the Committee shall not be eligible to succeed themselves.

DR. OWENS: Your Committee recommends the approval of both of these and I move the approval of the first one I read at this time. (This motion was seconded)

THE CHAIR: Gentlemen, you have heard the motion. (The vote was unanimously in favor.) It is so ordered.

DR. OWENS: Now, your committee recommends the acceptance of the second recommendation, the new section, and I move its adoption. (The motion was seconded)

THE CHAIR: (Vote was unanimous) I declare both of them passed.

THE CHAIR: Thank you, Dr. Owens and your committee.

Now, before we go into the next order of business, I would like to call your attention to an item in the program, on Page 5, please turn to Page 5. One of the problems we have had during the years is to have a good representation at our opening sessions on Thursday mornings of our conventions. We have a good meeting on Wednesday, we have a lot of people in town on Thursday, but they are in various states of confusion and despair early Thursday morning and very often they sleep so late that they can not get breakfast and get to the meeting so that we have been embarrassed on several occasions by having our speakers, who have come from a distance, speak to ten or fifteen people which is not good for us or for them, either. So, realizing that problem the Alumni Association offered as part of their services to us, to put on a breakfast for members of the Alumni Association tomorrow morning at 8:30. The reason I am calling your attention to this is the fact that Joan says she has only sold eight tickets and they are only $1 a piece, you will get breakfast for only $1, the Alumni Association is going to pay the other 50 cents. Please pick up your tickets and pass the word around that we are trying to have the doctors together so that the meeting can be started on time. Now, since I am not a visiting dignitary and I don't care whether two or three of you are there, or a lot, (you know I would like to have a lot of you there!) so as soon as breakfast is over I am going to give my annual report, trying to gain a little time for our speakers on the Scientific Program. However, I would consider it a great compliment if you would get up at 8:30 and have breakfast and after breakfast I will give my report. Dr. Mobley, Chairman of the Memorial Committee, will also give his report, but the urgency of the situation requires that we get the tickets so they will know how many people to prepare for. I would like for you to come, if you can, and if you can't, come as soon after breakfast as you can.

THE CHAIR: The next report is that of the reference Committee on Insurance, Blue Cross and Blue Shield, Dr. John A. Siegling, Chairman, Charleston. Dr. Siegling.

DR. JOHN A. SIEGLING: Mr. President, the Committee on Insurance, Blue Cross and Blue Shield, Doctors G. D. Johnson, William Hunter, Wyman King and John Siegling considered the problems referred to their committee, and wish to report as follows:

Insurance

(1) We wish to commend the Insurance Committee, consisting of Doctors A. C. Bozard, J. D. Gilland and Kenneth Lawrence, Chairman. It is obvious that they have given a great deal of time and thought to their report and the affairs of the Committee throughout the year. In line with its recommendations, we

(a) recommend that the South Carolina Medical Association continue to encourage the work of an active Insurance Committee. I so move. (This was seconded, there was no discussion, the vote was taken and it was so ordered.)

(b) recommend approval of the Group Life Insurance for members of the Association offered by Messrs. J. B. Talbert and O. E. Stubblefield, and underwritten by the Home Security Life Insurance Company. I so move.

(This was seconded, there was no discussion, the vote was taken and motion carried.)

(c) disapprove a plan of major hospital expense coverage offered by the Commercial Insurance Company of New Jersey represented by the General Agency, Mr. John B. Cappelmann, Jr., of Charleston, since our own South Carolina Medical Care Plan will offer a similar plan in the near future, and since we have a program of liability coverage with the Educators

Mutual which is working satisfactorily. I so move. (This was seconded.) The committee moves disapproval of a plan of major hospital expense coverage offered by a commercial insurance company, as that plan required going into a life insurance feature which we feel is already covered.
The motion was carried.
DR. SIEGLING:
(d) We move approval of the Retirement Plan offered by Mr. William Webber of Washington, D. C., through the Minnesota Mutual Life Insurance Company. I so move. (This was seconded, the vote was taken, and carried.)
2. We move that the Industrial Fee Schedule Committee report as rendered by Dr. W. W. Edwards, Chairman, be accepted and that the *Journal* carry a notice when the Fee Schedule is finally accepted by the Industrial Commission. I so move.
(This was seconded.)
THE CHAIR: Is there any discussion?
DR. N. O. EADDY (Recognized): I would like to ask that when the fee approval is published that the Schedule, itself, be published. It was published quite a while back, most of us don't have it and don't know what the changes will be. It is not only notice of the fact that this schedule has been approved, with which we are concerned, if you will leave it up to Dr. Waring and it meets with his approval, I would make the suggestion that the new fee schedule, itself, be published in the Journal.
THE CHAIR: Is that an amendment to Dr. Siegling's motion?
DR. EADDY: No, I just offered it as a suggestion.
THE CHAIR: Is there any further discussion? Your suggestion is not going to pass, Dr. Eaddy, if you don't make a motion out of it.
DR. EADDY: All right.
THE CHAIR: All in favor of Dr. Siegling's motion when the fee schedule is adopted by the Industrial Commission that a notice be put in the Journal, signify by saying "aye" opposed—"no". It is so ordered.
DR. JOHN SIEGLING:
3. We commend the Directors of the Benevolence Fund and hope that it will continue to grow. We move acceptance of the report as printed. (This was seconded, there was no discussion, the vote was taken and the motion was carried.)
4. We recommend acceptance of the report of the Committee on Care of the Patient, as printed. I so move. (This was seconded, there was no discussion, the vote was taken and it was so ordered.)
5. Finally we would like to acknowledge the debt of the Association to Dr. Frank Owens, Chairman of the Medical Advisory Committee on Selective Service, who has for so long kept us informed, and recommend acceptance of his report as given before the House of Delegates. I so move. (Seconded, there was no discussion, the vote was taken and motion carried.)
DR. SIEGLING: Mr. President, I now move acceptance of this report as a whole. (Motion seconded, it was voted on and carried.)
THE CHAIR: Thank you, Dr. Siegling.
The next reference committee is that on Miscellaneous Business, Dr. Robert Clarke, Chairman, Due West, Dr. Clarke.
DR. ROBERT CLARKE: Mr. President, The following reports and resolutions were considered by your reference committee. Three of these have already been considered by other reference committees, and I will omit those which have already been covered.
DR. CLARKE:

Accident Prevention

1. Report and recommendations of the S. C. Medical Association's Accident Prevention Committee—the reference committee recommends that this committee be commended for its report and that the report be accepted with the following exception. That that part of the report referring to lead missiles in air rifles, pellet guns, etc., be referred to an appropriate committee for the purpose of study and presentation to the state legislature. I so move. (Motion was seconded the vote was taken and unanimously passed.)
Further, it is recommended that the State Association actively cooperate with the Cornell University Crash Injury Research Unit. I so move, Mr. President.
(Motion was seconded, vote taken, and the motion was carried.)

Historical Medicine

2. Report on Historical Medicine, the reference committee recommends that the customary $500.00 be allocated to the work of this committee. I so move, Mr. President. (Seconded, voted on and the motion was carried.)
3. The resolution from the Executive Committee of the Spartanburg Medical Society, relating to appealing to the American Medical Association for initiation of an active and vigorous pro-physician propaganda program was approved by the reference committee in principle, however, it is recommended that this resolution be referred for further study to a proper committee having more knowledge of the current efforts and facilities of the American Medical Association along public relation lines, as your reference committee feels it is not well enough informed as to the present A. M. A. program. I so move. (Seconded, no discussion, vote taken and the motion was carried.)

Social Security Poll

4. The request by the Greenwood County Medical Society that the members of the S. C. Medical Association be polled as to their present wishes in regard to the social security system was considered and your reference committee recommends that during the coming year this poll be taken. I so move, Mr. President. (The motion was seconded, there was no discussion, the vote was taken and the motion was carried.)
5. Report of the A. M. E. F. Committee for 1960—your reference committee recommends that this report be adopted. I so move, Mr. President. (This motion was seconded, there was no discussion, the vote was taken and it was so ordered.
6. Advisory Council to the Woman's Auxiliary—your reference committee recommends that the report of this committee, as published in the *Journal*, be adopted. I do move, Mr. President. (This motion was seconded, there was no discussion, the vote was taken and the motion was carried.)
7. Report of Committee on the Scientific Program—no report was received from the Scientific Program Committee.
8. Report of Committee on Liaison with Allied Professions—your reference committee approves the report of the Committee on Liaison with Allied Professions and moves that its recommendations, as printed in the *Journal*, be adopted. I so move, Mr. President. (This was seconded, the vote was taken and the motion was carried.)
Mr. President, this concludes our report and I move that the whole report of the reference committee on Miscellaneous Business be approved. (This was seconded, voted on and accepted.)
Gentlemen, this concludes the work of the reference committees and I want to thank the Chairman and members of these committees for the hard work and when I say "hard" I mean hard. I stopped in on two or three of those committees yesterday afternoon and those boys were sweating it out. You fellows were probably there helping some of them sweat, but we all owe them a debt of gratitude because it is only in committees that we can get these things thrashed out. If we had to take up all of this on the floor of the House, we never would get through. I would like to

ask for a rising vote of thanks for all members of the reference committees. (The convention rises and applauds.)

Elections

THE CHAIR: Gentlemen, we go into the order for election of officers. Nominations are now in order for the office of President-Elect, of the South Carolina Medical Association.

DR. W. O. WHETSELL, Orangeburg (Recognized by the Chair):

Mr. President, the Edisto Medical Society proposes Dr. J. H. Gressette as President-Elect of the South Carolina Medical Association. Dr. Gressette is a native of St. Matthews, a 1938 graduate of the South Carolina Medical College, a diplomate of the Board of Otolaryngology and Ophthalmology and a member of the American College of Surgeons. He has been practicing in Orangeburg since 1945, a member and past president of the Edisto Medical Society and the South Carolina Society of Ophthalmology and Otolaryngology. He has been a member of the Council for the past nine years and is at present the Chairman of the Council. As a delegate from the Edisto Medical Society I should like to nominate Dr. Gressette.

DR. GAINES, Anderson, (Recognized by The Chair): As a member of the S. C. Society of Ophthalmology and Otolaryngology I should like to say a word about Dr. Gressette. When he finished his residency and came back to South Carolina, those of us who were here already in that specialty soon felt the impact of his coming. In the past years we have learned to respect his integrity, his learning in his profession and it has increased during the years. As one, who is fairly familiar with the naturopathy question and the question of optometry, as related to the South Carolina medical profession, I should like to take this opportunity to pay my respect to his level-headedness and his good judgment in such affairs, also to his entry into the law making body of South Carolina. I should think that our Association would be in good hands with his leadership and I take great pleasure in seconding his nomination.

THE CHAIR: Does anybody else want to second?

DR. L. P. THACKSTON, Orangeburg: Gentlemen, I take a great deal of pleasure in saying a few words about a man that I know doesn't need anyone to bring out his good qualities, I am sure. Dr. Gressette is an excellent professional man. I am speaking of him from a different angle. He is an excellent medical man and he will carry the colors for us up or down, in or out, and he can be absolutely depended upon, whether the going is nice or whether the going is rough. He will make no effort to ramrod a proposition or a resolution or a nomination through this organization. I would like to take the liberty of making a motion that the nominations be closed.

THE CHAIR: Dr. Thackston, I will rule that motion out of order because I want to give plenty of opportunity to have somebody nominated here, and if nobody else wants to nominate anybody we will close it right quick, but Dr. Poda wants the floor. Dr. Poda recognized.

DR. PODA: After all the hell we have raised about re-registration I don't know if Aiken County would be quite welcome on the floor. We and the delegates from Aiken County have unanimously told that if Dr. Gressette was to be presented the society as a whole wishes to say they would very, very much like to see him as president-elect. Those of us who have had contact with him have found him to be a most commendable citizen as well as a doctor. We think he would do the Association a terrific job and would like to add our second to those already on the floor.

THE CHAIR: Are there any other nominations?

DR. WILSON: I would like to move, Mr. Chairman, that the nominations be closed and Dr. Gressette be elected by acclamation. (This motion was seconded)

THE CHAIR: Dr. Wilson moved that the secretary be instructed to cast a unanimous ballot of the Association to elect Dr. J. H. Gressette president-elect of the S. C. Medical Association. (The vote was taken and the motion carried.)

The new President and the President-elect. Dr. Gressette, President-elect; Dr. Wyatt, president.

Gentlemen, the floor is open for nominations for vice-president. We may have a slight delay if our president-elect comes in the door, but while we are wating for Dr. Gressette we will go on.

DR. NORMAN EADDY (Sumter): I would like to nominate as vice-president of this Association Dr. Wallis D. Cone, of Sumter.

THE CHAIR: Dr. Cone has been nominated as vice-president. Here comes our president-elect, gentlemen, let's all rise. (House rises and applauds until Dr. Gressette reaches the podium)

THE CHAIR: Truly this is a great surprise.

DR. GRESSETTE: Should I be surprised? Thank you very much, we will do the best we can. Hope we don't step on your toes, but we will be doing what we think is the best for the Association and I hope that I will live long enough to follow Charlie Wyatt.

THE CHAIR: Gentlemen, Dr. Wallis Cone, of Sumter, has been nominated for vice-president. If there are no further nominations do I hear a motion that the nominations be closed and that Dr. Cone be unanimously elected?

(Motion made by Dr. Thackston, seconded by Dr. Evatt, the vote was taken and it was so ordered.)

DR. EADDY: I would like to point out that both of these boys are from Orangeburg or thereabout, and we will be in pretty good hands.

THE CHAIR: You should have pointed that out beforehand.

DR. EADDY: We should have known that beforehand.

THE CHAIR: Nominations are in order for Secretary.

DR. CHARLES WYATT: Mr. Chairman, I nominate the present incumbent. (This was seconded by several.)

Dr. Robert Wilson was re-elected.

THE CHAIR: The office of treasurer, this nomination comes from the Council and the present Chairman of Council, who is still Chairman, will please make the nomination.

DR. GRESSETTE: Mr. President, Council looked all over the entire membership and we found that to nominate anyone other than Howard Stokes that we would come up wanting, so, Council recommends and

nominates Howard Stokes for Treasurer of the South Carolina Medical Association at this same time.
Dr. Howard Stokes was elected treasurer.

THE CHAIR: The next is the Delegate to the A.M.A., Dr. William Weston, Jr.; his term expires December 31, 1961.

DR. FRANK OWENS (Recognized): Mr. President and members of the House of Delegates, there are many men in here who could make fine delegates to the American Medical Association to represent our South Carolina Association. There are two in particular, though, who have some assets that perhaps the others do not have. One of them is George D. Johnson, who has been up there for several years and is making us a wonderful representative. The other man is a man who is very firm in his convictions, who is very forceful in his presentation of his views and the views of the South Carolina Medical Association, a man who has worked his way up, you might say in the medical world, he was President of the Columbia Medical Society one time, President of the S. C. Medical Association, has been representing us for the last nine years in our national body. It is quite an advantage when you have had an opportunity to meet all these doctors over the country who are delegates to the A.M.A. There are things that come up in which friendship is worth a great deal. You can put views before a group but you can accomplish a great deal by talking to them in rooms and corridors and things of that kind, so I have the pleasure and honor of placing in nomination, to succeed himself as delegate to the American Medical Association from South Carolina, Dr. William Weston, Jr. (Second)

THE CHAIR: Are there any further nominations?

DR. P. F. LaBORDE, Jr. (Columbia: I would like to nominate Dr. Joe Cain.

DR. CAIN (THE CHAIR): You put me on the spot. I am going to turn the chair over to Dr. Workman. I assure you this is entirely spontaneous, I do not know how the vote will go. I am not running against Dr. Weston. If I can help, I will be glad to do it but if you do not want to elect me I won't be mad. This is spontaneous, I don't know how to handle it, I am going to get out. (Dr. Cain leaves the room, and Dr. Workman takes the Chair.)

DR. WORKMAN: Do I hear a second?

(There were several seconds from the floor)

(The suggestion was made from the floor that time would be saved if the voting were by secret ballot.)

Gentlemen, vote by secret ballot for Dr. William Weston, Jr., or Dr. Joe Cain for Delegate to the American Medical Association. First, are there any other nominations?

(Dr. Evatt moved that the nominations be closed, seconded by Dr. Wyman, the vote was taken and it was so ordered.)

In order to save time while we are counting these ballots, we will entertain a motion for an alternate delegate to the A.M.A., a two-year term, the term of Dr. Frank C. Owens expires, Dec. 31, 1961.

DR. O. B. MAYER (Recognized): I would like to place the name of Dr. Frank C. Owens to succeed himself as the alternate delegate to A. M. A., for a term of two years. (This was seconded by Dr. Crawford, and motion made that nominations be closed. This was duly seconded, voted on and carried.)

THE CHAIR: (Dr. B. J. Workman)—Dr. Frank C. Owens is elected to succeed himself as Alternate Delegate to the A.M.A.

Gentlemen, Dr. Cain has been elected as Delegate to the A.M.A. Will someone ask Dr. Cain of he will return to the room, please. (Dr. Cain comes into the room) Dr. Joe, you have been elected Delegate to the A.M.A., congratulations.

DR. CAIN: Gentlemen, I hardly know what to say, you caught me completely by surprise and it is much better that you did. I will certainly do my best to represent you in the A. M. A. in a way in which you will be proud. Thank you very much.

DR. CAIN: (Presiding) We will now go into the election of Councilors. Councilor for the Second District has finished two terms, Dr. A. F. Burnside is eligible for one more term. Nominations are now in order for Councilor from the 2nd District.

DR. COOK (Recognized): The representatives of the Second District would unanimously like to place in nomination the name of our present councilor, and vice-president of Council, Dr. A. F. Burnside. (This was seconded, motion was made by Dr. Poda that the nominations be closed and that Dr. Burnside be elected by acclamation, this was seconded, voted on and carried.)

THE CHAIR: Dr. Burnside is elected to succeed himself as councilor from the 2nd District.

The Term of Dr. John M. Brewer expires, the 5th District. His term expires this year. He is eligible for re-election.

DR. LaROCHE: (Recognized) I would like to place the name of Dr. John Brewer in nomination for re-election. (There were no other nominations, motion was made that the nominations be closed and that Dr. Brewer be elected by acclamation. This was seconded, voted on and carried.)

THE CHAIR: Dr. Brewer is elected from the 5th District.

The 8th District, Dr. Gressette having been promoted no longer fills this office. It is wide open and nominations are in order for councilor from the 8th District.

DR. HARVEY ATWILL, Orangeburg (Recognized): We would like to place in nomination the name of Dr. Joseph D. Thomas, of Denmark, as councilor from the Eighth District. (Mr. M. L. Meadors was called by The Chair to come to the rostrum)

THE CHAIR: Are there any further nominations? (Motion made that nominations be closed, this was seconded, voted upon and passed) Is Dr. J. D. Thomas with us? Would you please stand up, Dr. Thomas? (The house applauded when Dr. Thomas stood.) This is your new councilor from the 8th District.

Gentlemen, we will now go into the election of the Mediation Committee and the terms of those members from the 2nd, 5th and 8th Districts have expired. The council from each of these districts has nominated two men, whose names will be placed on the blackboard and I will ask the tellers to prepare the ballots. Now, prepare your ballots in this manner, we will put it all on one ballot, mark 2nd District, 5th District, and 8th District and then write down the name of the man for whom you are voting, according to the nominees who are put on the board. (Mr. Meadors puts the nominees on the blackboard.)

I have an announcement. The Chairman of the Mediation Committee has called a meeting of this committee, the old members and also the ones about to be elected now, immediately after this meeting has adjourned in the front part of this room, right up there by the steps.

THE CHAIR: While the ballots are being prepared and the names are being written on the board we will elect a member of the Benevolence Fund Committee, the term of Dr. Thomas G. Goldsmith expires. This nomination comes from Council, Dr. Gressette?

DR. GRESSETTE: Council would like to nominate Dr. Goldsmith to succeed himself.

THE CHAIR: Dr. Tom Goldsmith has been nominated to succeed himhelf as a member of the Benevolence Fund Committee. (This was seconded) There were no further nominations from Council, you can either elect or reject him. (The vote was taken and carried.) Dr. Thomas Goldsmith succeeds himself as a member of the Benevolence Fund Committee.

(The Blackboard shows the following nominees for

the Mediation Committee)

2nd District
W. H. Bridgers
G. A. Poda
5th District
Ripon W. LaRoche
Halsted Stone
8th District
Henry Gibson
James Wells

THE CHAIR: Mark your ballots, 2 - 5 - and 8 and vote for one man for each district on a plain sheet of paper. Thank you.

State Board of Medical Examiners

THE CHAIR: Two vacancies for a four-year term. One for the First Congressional District, the term of Dr. A. R. Johnson expires, and the other is the Third Congressional District, Dr. Wm. P. Turner, Jr. term expires.

Nominations are now in order for a member of the State Board of Medical Examiners from the 1st Congressional District. Dr. Hugh Pearson, Beaufort, recognized.

DR. PEARSON: Our delegation would like to place in nomination Dr. Wescoat A. Black's name as a member of the State Board of Medical Examiners from the First Congressional District. In 1935 in this city and I believe in this room Dr. Black was duly elected representative from his district, which was the Sixth at that time, also during that year due to a shift in the allocation of counties to the Congressional Districts Dr. Black was disqualified and never allowed to serve. He has been a practicing physician in Beaufort for the last 30 years, he graduated from the Medical College here in 1927 and has been an active Blue Cross representative for the past eight years. Those of us who know him think he would be a capable addition and a capable member of this board. (This nomination was seconded)

THE CHAIR: Any further nominations? Dr. Harvey Atwill, (Recognized)

DR. ATWILL, Orangeburg: I would like to place in nomination the name of Dr. A. R. Johnston, of St. George, who has done an admirable job.

"Have you got everything, dear? Your hat, your coat, your case, your snarl?"

THE CHAIR: Dr. A. R. Johnston has been nominated to succeed himself. Are there any other nominations? (There were none.)

THE CHAIR: Has everybody voted for the Mediation Committee? Now, prepare your ballots for a Member of the State Board of Medical Examiners from the 1st Congressional District—Dr. A. R. Johnston or Dr. Wescoat Black, vote for one.

Nominations are now in order for a member to the State Board of Medical Examiners from the Third District, the Third Congressional District, are there any nominations?

(DR. ---------?) I move that Dr. Wm. P. Turner, Jr., be re-elected to succeed himself.

THE CHAIR: Dr. Turner has been nominated. Are there any other nominations? (Motion was made that the nominations be closed, this was seconded, voted on and The Chair declared Dr. Turner re-elected to succeed himself.)

Gentlemen, we will now elect a member of the Hospital Advisory Council to the State Board of Health.

DR. JOHN M. BREWER (Recognized): Mr. President, I move we put this off or delay this election until this tabulation is made.

THE CHAIR: Dr. Brewer has made a motion that we delay further elections until the tabulation has been made, are there any seconds to the motion? (The motion was seconded, the vote was taken and passed.) We will have a short recess. Don't get too far off.

(The Chair asked if there was anyone who had not voted on the State Board of Medical Examiners, and one doctor brought his ballot forward.)

THE CHAIR: Gentlemen, Dr. A. R. (Dick) Johnston has been elected to succeed himself as a member of the State Board of Medical Examiners from the 1st Congressional district.

We will go on and elect the members of the Hospital Advisory Council to the State Board of Health.

DR. BREWER: Mr. President, we would like to delay this until we get a report on these other committees, I believe that was my motion, before.

THE CHAIR: If that is your motion, we will continue the recess, until we get this thing straightened out.

(Tellers report on election of the Mediation Committee.)

THE CHAIR: Gentlemen, the results of the balloting on the Mediation Committee:

2nd District—Dr. W. H. Bridgers has been elected.

5th District—Dr. Ripon LaRoche has been elected.

8th District—Dr. James Wells has been elected.

THE CHAIR: Now, we will elect members of the Hospital Advisory Council to State Board of Health, do I hear any nominations, the term of Dr. J. C. Harris expires.

(DR. BREWER?): I would like to place in nomination the name of Dr. Halsted Stone. (Seconded by Dr. Wallace.)

DR. ROBERT WILSON: Mr. Chairman, I would like to nominate Dr. T. C. McFall.

THE CHAIR: That nomination is out of order right this minute. I am trying to get the ones for Dr. Harris, right now. I may be wrong in that ruling, but I am under the impression these are geographically situated. Is that true or not? (Someone from the floor stated they were not geographical.)

I will rule that we will vote on nominees—we will vote on two of the nominees. Dr. Stone has been nominated and Dr. McFall has been nominated, and we will vote on two. Are there any other nominations? (Motion was made that the nominations be closed, this was seconded.)

The motion is that the nominations be closed and that these two gentlemen be unanimously elected to the Hospital Advisory Council. (Vote was taken and it

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was so ordered, the vote being unanimous.)

We will now have to elect a committee on Emergency Medical Care, these men are nominated by Council, Dr. Gressette, Chairman.

DR. GRESSETTE (Chairman of Council): Mr. President, Council makes these nominations for a Committee on Emergency Medical Care: Bill Herbert, Charles May, Graham Shaw, R. S. Solomon, and Ray Ackerman, these we nominate, the first for a term of one year, the second and on down the line, two, three, four and five years. Thank you. (Seconded)

THE CHAIR: You have heard the nominations, all in favor of these nominations say "aye", opposed "no", it is so ordered.

THE CHAIR: Gentlemen, the final order of business is the selection of a place of meeting for 1962.

THE CHAIR: Thank you both very much. We have been invited to Greenville and Myrtle Beach and both are fine places and good hotels, now we must decide where we want to go.

DR. OWENS: I would like to make the motion to this effect that this group express the preference as to which it prefers but that the final decision of the place we go be left to Council. The reason is if we decide to go definitely then Council wouldn't have any bargaining point at all as far as charges, and things of that kind. If we express a preference then Council will be warned, but they are still in a bargaining position to get the best deal out of the hotel.

THE CHAIR: Dr. Owens has made a motion that the House express a preference but leave it to the discretion of Council for a final decision, and that final decision will be based on what, the preference that we made here, or what?

DR. OWENS: It will be based on the decision of Council.

THE CHAIR: Well, why is it necessary for us to cite a preference?

DR. OWENS: Council would like to know what the feeling of this group is.

THE CHAIR: In other words, they would like to know whether or not they would be bound by it. That is your motion, Council would be in no way bound by this?

DR. OWENS: No, this is a recommendation but not a binding vote. (The motion was seconded. There was no discussion.)

THE CHAIR: We are voting on the motion, not the place, not our preference. All in favor say "aye". All opposed "no". (The vote was unanimous in favor of the motion.)

Now, what is your preference?

DR. GAINES: A standing vote.

THE CHAIR: For what?

DR. GAINES: Ask all that want to go to the beach, stand up, and all those who want to go to Greenville, stand up.

THE CHAIR: All those who want to go to Greenville, stand up. (Tellers count them) All those who want to go to Myrtle Beach stand up. (The report was 27 to go to Greenville and 43 to go to Myrtle Beach.)

Gentlemen for your information, regardless of Council the majority here want to go to Myrtle Beach. I hope Council understands Dr. Owens' motion, that is advice only, and other factors will be considered.

Gentlemen, the meeting is not adjourned. The Chair at this time extends the floor to Dr. James H. Gressette.

DR. GRESSETTE: I tell you, this floor is hard to get from Joe, he promised me this morning I would get the floor for this purpose early this morning and here it is the last thing. At this time, Dr. Workman, the society would like to present this to you for being our Vice-President last year, for all you have done and we have enjoyed having you work with us. (Gift is handed Dr. Workman)

DR. WORKMAN: I want Joe Cain to be assured it has been a real pleasure to work with him this year, the only thing—I have had difficulty in keeping up with him. I appreciate this very much and as the years go by it will remind me of very fond memories.

DR. GRESSETTE: The other one is an unusual surprise, too, "the South Carolina Medical Association presents to Joseph P. Cain, Jr., M. D., this certificate of office held in this Association, in grateful appreciation of his service. President 1960-61, Chairman of Council 1954-59, Robert Wilson, Secretary."

Joe, I could take this and I could discuss—I could tell them how many times I have seen you get mad and prespiration running down your back, when somebody crossed you up in a meeting on the floor, and I tell you that we appreciate it, we appreciate all you have done for us and we appreciate all you are going to do for us.

DR. CAIN: Thank you.

Is there any further business? Have we forgotten anything? This is the end now, no argument until next year.

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